

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08240

CERTIFICATE OF DEATH

08229

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 2732 W. Fairmount Avenue			
3. NAME OF DECEASED (Type or print) First JAMES Middle (NMI) Last ALEXANDER				4. DATE OF DEATH Month August Day 11 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, 1900	
9. AGE (In years last birthday) 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		11. BIRTHPLACE (State or foreign country) Tampa, Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Alexander				14. MOTHER'S MAIDEN NAME Fannie Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 134-03-9197		17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLISM & INFARCTION, THROMBOSIS OF LEFT & RIGHT AURICLES DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 8, 1957 , to August 11, 1957 , that he was the deceased alive on August 11, 1957 , and that death occurred at 6:10 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED CHHEN WEI LAN, M. D. VAH, FORT HOWARD, MD. 8/12/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/15/57		22c. NAME OF CEMETERY OR CREMATORY MT. AUBURN National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Rice				24a. REC'D BY REGISTRAR DATE 8/10/57		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

CERTIFICATE OF DEATH

BUREAU V. S.

JUG 20 1957

RECEIVED

08241

CERTIFICATE OF DEATH

08230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-TOWSON</u>				c. LENGTH OF STAY IN lb <u>5WKS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT-1-BOX 182-BLENHEIM RD</u>				d. STREET ADDRESS <u>BOX 182-BLENHEIM RD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>KATIE VIOLA BAILEY</u>				4. DATE OF DEATH Month Day Year <u>AUG. 28 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHT.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC 14, 1878</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>212-14-7281</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN HORSEMAN</u>				14. MOTHER'S MAIDEN NAME <u>SALLIE BROWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-144281</u>		17. INFORMANT Address <u>ETHEL FLEMING - FOREST HILL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>10</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Aug 7th 1957</u> , to <u>Aug 28th 1957</u> , that I last saw the deceased alive on <u>Aug. 28th 1957</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1927 York Rd., TIMONIUM Md, 8/28/57</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>M. X. Quinn</u> M.D. _____ PHYSICIAN'S NAME (Type) <u>M. KEVIN QUINN M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Aug 31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HEBRON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HEBRON-WIC. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook, Inc</u> ADDRESS <u>1217 ST. PAUL ST.</u>				24. REC'D BY REGISTRAR <u>AUG 30 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Michel Gray</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

AUG 30 1957

BUREAU V. S.

RECEIVED

08242

Item 4 Film 9220 9-6-57 et

CERTIFICATE OF DEATH

08231

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Geo. Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights, Maryland 16x0.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 7108 Belwood St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle Bernadette Last Barbeau				4. DATE OF DEATH Month August Day 27 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1908	
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Massachusetts	
13. FATHER'S NAME Thomas Cannon				14. MOTHER'S MAIDEN NAME Susan Miller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portal Cirrhosis of liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 6 , 19 57 , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Ellis S. Mary M.D.				SPRING GROVE STATE HOSPITAL			
PHYSICIAN'S NAME (Type) Catonsville 28, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-30-57		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET Cem.		22d. LOCATION (City, town, or county) (State) WASH D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Timothy Harlow				24a. REC'D BY REGISTRAR AUG 29 '57		24b. REGISTRAR'S SIGNATURE Alfred	

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CERTIFICATE OF DEATH

RECEIVED
AUG 29 1957
BUREAU V. S.

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SOCIAL SECURITY NUMBER		12. MANNER OF DEATH	
13. PLACE OF DEATH		14. TIME OF DEATH		15. CAUSE OF DEATH		16. MEDICAL HISTORY		17. HISTORY OF PRESENT ILLNESS		18. SIGNATURE OF PHYSICIAN	
19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF FUNERAL HOME		22. SIGNATURE OF CORONER		23. SIGNATURE OF JUDGE		24. SIGNATURE OF CLERK	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08243

CERTIFICATE OF DEATH

0823238

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Armacost Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Kingsville</u> d. STREET ADDRESS <u>Hillside & Cross Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Christine</u> First <u>Bathelmes</u> Middle <u>R</u> Last				4. DATE OF DEATH <u>Aug</u> Month <u>22</u> Day <u>57</u> Year <u>19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 14 1891</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>V.S.</u>							
13. FATHER'S NAME <u>George Kammer</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Fehr</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-07-2995</u>		17. INFORMANT <u>Frdek W Barthelmes 122 Elinor Ave Balto 6 Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis with cardiac decompensation</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. <u>360X</u> (b) <u>arteriosclerotic cardiovascular disease - Generalized</u> DUE TO <u>arteriosclerotic atherosclerosis with hypoplasia</u> (c) <u>Diabetes (with overlapping Retinal Hemorrhage) Carcinoma - Pancreas</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gangrenous ulceration Dorsum Rt. Foot, Beginning gangrene Lt. leg - 4th</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>3 yrs. +</u> <u>Diabetes 3 yrs +</u> <u>Arteriosclerosis 2 yrs +</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>November 11, 1954</u> , to <u>August 22, 1957</u> , that I last saw the deceased alive on <u>August 21, 1957</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Bal Air Rd - Kingsville</u> DATE SIGNED <u>Isabel H. McClinton M.D.</u>							
ACTUAL SIGNATURE <u>Isabel H. McClinton M.D.</u>				PHYSICIAN'S NAME (Type) <u>Isabel H. McClinton M.D.</u> <u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>August 26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ullrich Funeral Home 4210 Belair Road</u> ADDRESS				24a. REC'D BY REGISTRAR <u>AUG 28 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Isabel H. McClinton</u>			

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

11-20-57

24 1/2

37 MON 17 28

The undersigned, a duly qualified physician, do hereby certify that the above named person died on the 17th day of August, 1957, at the age of 24 1/2 years, of a disease of the heart, which was the result of a long-standing condition of the heart, and which was not due to any other cause.

BUREAU V. B.

AUG 29 1957

RECEIVED

Isabel H. Williams, M.D.
 100 State Street, Boston, Mass.
 August 29, 1957

08244

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.				c. LENGTH OF STAY IN 1b 148 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle C. Last BARTLETT				4. DATE OF DEATH Month August Day 31 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11/18/94	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Rubber Company		11. BIRTHPLACE (State or foreign country) Charlottesville, Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Bartlett				14. MOTHER'S MAIDEN NAME Virginia Hoover			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I				16. SOCIAL SECURITY NO. 274-05-8406		17. INFORMANT Clin. Records, Vet. Adm. Hosp., Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INFARCT MULTIPLE DUE TO AURICULAR THROMBOSIS, BILATERAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Due to: AORTIC STENOSIS AND INSUFFICIENCY (c) HEART INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that VA attended the deceased from April 5, 1957 to August 31, 1957 . Death occurred at 2:30 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 9-1-57 ACTUAL SIGNATURE Chien Wei Lan M.D. VAH, FORT HOWARD, MARYLAND 9-1-57 PHYSICIAN'S NAME (Type) CHIEN WEI LAN M.D. VAH, FORT HOWARD, MARYLAND 9-1-57							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/4/57		22c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE WM. J. TICKNER & SONS, INC.				24a. REC'D BY REGISTRAR North & Pennsylvania Ave., Baltimore, Md.		24b. REGISTRAR'S SIGNATURE 9/3/57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

SEP 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08245

Item 5.2.5.1.2.20 2-6-7 et

CERTIFICATE OF DEATH

08234

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Towson</u> 12 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>405 Hopkins Road</u>				d. STREET ADDRESS <u>1405 Hopkins Road</u>			
3. NAME OF DECEASED (Type or print) First <u>Salvatore</u> Middle <u>Battaglia</u> Last				4. DATE OF DEATH Month <u>8</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-25-1869</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Produce</u>		11. BIRTHPLACE (State or foreign country) <u>Cefalu Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>John Battaglia</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>John F. Battaglia</u>				Address <u>405 Hopkins Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerotic cardio vascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>January 15, 1954</u> to <u>August 30, 1957</u> , that I last saw the deceased alive on <u>August 30, 1957</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8/30/57</u> DATE SIGNED							
ACTUAL SIGNATURE <u>Philip D. Flynn</u> M.D. <u>11 East Chase Street, Baltimore 2, Md.</u>							
NAME (Type) <u>Philip D. Flynn, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-2-1957</u>		<u>New Cathedral Cemetery</u>		<u>Fredrick Rd. Balto 29-Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Garas Inc. 712-14 E North Ave</u>				24. REGISTRAR'S SIGNATURE <u>REC'D BY REGISTRAR Aug. 31 1957 RW. Mabel Gray</u>			

BUREAU V. B.

1957 3 1

RECEIVED

08246

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b Baltimore d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3529 Old Frederick Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle C. Last Beard		4. DATE OF DEATH Month August Day 24 Year 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1972
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Taylor		14. MOTHER'S MAIDEN NAME Fannie Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Mrs. Fannie Thompson		Address 3529 Old Fred. Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Sigmoid Colon 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from April 2, 1957 , to August 24, 1957 , that I last saw the deceased alive on August 16, 1957 , and that death occurred at 11:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE C. Arthur Rosenberg MD		ADDRESS (Street, city or town, state) 2436 WASHINGTON BLVD BALTIMORE 30 MARYLAND	
DATE SIGNED 8/26/57			
PHYSICIAN'S NAME (Type) C. ARTHUR ROSSBERG MD		BALTIMORE 30 MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-27-57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	22d. LOCATION (City, town, or county) (State) Woodlawn Md.
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville Md.		24a. REC'D BY REGISTRAR DATE AUG 28 57	
24b. REGISTRAR'S SIGNATURE Duf...			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08247

CERTIFICATE OF DEATH

08236

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUTHERVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HOWARD M. BENSON		4. DATE OF DEATH 8 / 10 / 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/21/83
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME THOMAS M. BENSON		14. MOTHER'S MAIDEN NAME SARAH THORNEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Chas. F. Benson		Address 1425 FRONT AVE.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prostatic Carcinoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June, 1957, to 10th Aug., 1957 , that I last saw the deceased alive on July 20, 1957 , and that death occurred at 8 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. K. Quinn		ADDRESS (Street, city or town, state) York Rd, TIMONIUM	
PHYSICIAN'S NAME (Type) M. K. QUINN		DATE SIGNED 8/10/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 8/13/57	22c. NAME OF CEMETERY OR CREMATORY MORELAND PARK	22d. LOCATION (City, town, or county) (State) BALTIMORE Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Mustis E. Enos		ADDRESS 3818 ROLING Ave.	
24a. REC'D BY REGISTRAR AUG 12 '57		24b. REGISTRAR'S SIGNATURE Per. Beach	

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AUG 12 1957
BUREAU Y. I.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08248

CERTIFICATE OF DEATH

08237

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 217 Montrose Ave.		d. STREET ADDRESS 217 Montrose Ave.	
3. NAME OF DECEASED (Type or print) First EUGENIE Middle CROLAIS Last BETTS		4. DATE OF DEATH Month Aug. Day 13 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1889
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) France		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henri Crolais		14. MOTHER'S MAIDEN NAME ? Hamon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Karl S. Betts		Address 217 Montrose Ave. Catonsville Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cerebrovascular disease 14X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 5 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from June 12, 1957 , to Aug 13, 1957 , that I last saw the deceased alive on Aug. 7, 1957 , and that death occurred at 9:45 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE John A. Nesbitt, Jr.		M.D. 1118 St. Paul St	
PHYSICIAN'S NAME (Type) JOHN A. NESBITT, JR		Baltimore 2, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/16/1957	22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem	22d. LOCATION (City, town, or county) (State) Arlington, Va.
23. FUNERAL DIRECTOR'S SIGNATURE Easton Stone		24a. REC'D BY REGISTRAR DAUG 19 57	
ADDRESS Catonsville 28, Md.		24b. REGISTRAR'S SIGNATURE DeLoach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 19 1957

BUREAU V. S.

08249

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7812 Overbrook Rd.				d. STREET ADDRESS 7812 Overbrook Rd.			
3. NAME OF DECEASED (Type or print) First LYLE Middle BLANCHARD Last BLANCHARD				4. DATE OF DEATH Month Aug. Day 26 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1888		9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Surveyor		10b. KIND OF BUSINESS OR INDUSTRY Marine Surveyors		11. BIRTHPLACE (State or foreign country) La.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Herman				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -yes		16. SOCIAL SECURITY NO. World War I		17. INFORMANT Address Mrs. Helena M. Blanchard - 7812 Overbrook Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 10, 1947 , to Aug. 26, 1957 , that I last saw the deceased alive on Aug. 26, 1957 , and that death occurred at 4:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6805 York Rd Baltimore 12, Md. DATE SIGNED							
ACTUAL SIGNATURE Laurence C. Post M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) LAURENCE C. Post				ADDRESS Baltimore 12, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8/29/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto.				24a. REC'D BY REGISTRAR DATE 30 1957		24b. REGISTRAR'S SIGNATURE Nobel L. Lickner	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 30 1957

BUREAU V. S.

1

INSTRUCTIONS

TO ATTEND PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08239

08250

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		STATE Maryland		COUNTY Baltimore			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Reisterstown		5 yrs		TOWN Reisterstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 434 Main Street				STREET ADDRESS (If rural give location) 434 Main Street			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Bertha (Middle) Elizabeth (Last) Bowersox				(Month) Aug (Day) 9 (Year) 1957			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH November 21 1880		9. AGE last birthday 76 yrs.	IF UNDER 1 YEAR Months 5 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin L Waltz				14. MOTHER'S MAIDEN NAME Julia Pennington Dingle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 176-26-0665		17. INFORMANT & ADDRESS Mrs Edna M Wolfe Reisterstown Md			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Coronary Thrombosis						5 minutes	
ANTECEDENT CAUSE(S) DUE TO (B) Congestive Heart Failure - Chronic						1 year	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 1956 to Aug 9, 1957 , that I last saw the deceased alive on Aug 9, 1957 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.							
SIGNATURE Charles E. Williams Jr. M.D.				DATE SIGNED Aug 10/1957			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Aug 13 1957		NAME OF CEMETERY OR CREMATORY Pipe Creek Cemetery		LOCATION (City, town, or county) Uniontown Md	
24. REC'D BY REGISTRAR 8-12-57		REGISTRAR'S SIGNATURE Mary B. Elmer		25. FUNERAL DIRECTOR'S SIGNATURE W. J. Berryman & Son		ADDRESS Reisterstown Md	

BUREAU V. S.

AUG 17 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08240

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b COUNTY	
b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Catonsville		c LENGTH OF STAY IN 1b 9yrlmth3dys	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f STREET ADDRESS 3216 Foster Avenue		g IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Martin Middle J. Last Brandt		4 DATE OF DEATH Month August Day 30 Year 19 57	
5. SEX male	6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1890
9 AGE (in years last birthday) 67 yrs		10 IF UNDER 1 YEAR Months 24 Days 24 Hours 00 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sea food dealer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11 BIRTHPLACE (State or foreign country) U. S. A.		12 CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME John Brandt		14 MOTHER'S MAIDEN NAME Margaret Fuchs	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] unknown		16 SOCIAL SECURITY NO unknown	
17 INFORMANT Records; SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 902 DUE TO Cardiac failure			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular disease			
(c) fracture left hip (former)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 7-18-57 Reduction and insertion of knee pin			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) fell while getting out of bed on 6-12-57 sustaining a sub-capital fracture of the left hip.	
20c. TIME OF INJURY Month, Day, Year Hour 5:00 a. m. 6-12 19 57		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> hospital	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Catonsville 28, Maryland		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE George M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9-2-57	
22c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.		22d. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD., MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiler		24a. REC'D BY REGISTRAR SEP 3 '57	
24b. REGISTRAR'S SIGNATURE Albrecht			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 7 1957

BUREAU W. B.

08252

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x? Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2519 Hilligord Drive</i>		d. STREET ADDRESS <i>2519 Hilligord Drive</i>	
3. NAME OF DECEASED (Type or print) <i>M Betty M. Burns</i>		4. DATE OF DEATH Month <i>August</i> Day <i>23rd</i> Year <i>19 57</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>Sept 23, 1906</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Ohio</i>
13. FATHER'S NAME <i>Henry Phibes</i>		14. MOTHER'S MAIDEN NAME <i>Alice Bailey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Doiores Lentz</i>		Address <i>2519 Hilligord Drive</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> <i>180x</i> DUE TO <i>Neoplasia of the Thymus Gland</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Neoplasia of the Thymus Gland</i> (c) <i>Neoplasia of the Thymus Gland</i>			INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct 10</i> , 19 <i>50</i> , to <i>August 23</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>August 23</i> , 19 <i>57</i> , and that death occurred at <i>5:20 A.M.</i> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <i>6201 York Road</i> DATE SIGNED <i>8/23/57</i>			
ACTUAL SIGNATURE <i>Charles E. Carr, Jr.</i>		M. D. <i>6201 York Road</i>	
PHYSICIAN'S NAME (Type) <i>Charles E. Carr, Jr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/26/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem Park</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Hargord Road #14</i>	
24a. REC'D BY REGISTRAR <i>AUG 27 1957</i>		24b. REGISTRAR'S SIGNATURE <i>R. M. Burns</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 27 1937

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08253

08242

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sue Island Middle River				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore Yacht Club				d. STREET ADDRESS 3139 Clifftmont Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Edwin Taylor Busch				4. DATE OF DEATH Month Day Year August 4 1957			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 7, 1904	
9. AGE (in years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Payroll Clerk				10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edgar Busch				14. MOTHER'S MAIDEN NAME Anna M. Schuster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-09-2789		17. INFORMANT Address Mrs. Madeline Busch, 3139 Clifftmont Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH 1 hr							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Jack C. Collins				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Jack C. Collins				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-7-57		22c. NAME OF CEMETERY OR CREMATORY Morland Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR DATE 8/8/57		24b. REGISTRAR'S SIGNATURE Edith Hurley	

MEDICAL CERTIFICATION

RECEIVED

AUG 8 1977

BUREAU V. S.

MEDICAL CERTIFICATION

VS A15 (4)
ISM 9/55

BUREAU V. S.

MAY 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Reg. Dist. No. 082442/											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2613 Royal Oak Ave.					d. STREET ADDRESS 2613 Royal Oak Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle L. Last BYRNE					4. DATE OF DEATH Month Aug. Day 1, Year 19 57						
5 SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 17, 1876		9. AGE (In years last birthday) 81 yrs.			
						IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY at home			11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William B. Anthony					14. MOTHER'S MAIDEN NAME Amelia V. Poole						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. W. Frank Reed - 522 Equitable Bldg.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Thrombosis (c) DUE TO stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE George M. Kieffer					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED Aug 57	
EXAMINER'S NAME (Type) George M. Kieffer											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 8/5/57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem. Md.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons - Baeto 17					ADDRESS		24a. REC'D BY REGISTRAR Dr. M. Kieffer		24b. REGISTRAR'S SIGNATURE		

RECEIVED

AUG 7 1977

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																								
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																								
Reg. Dist. No. 08245																								
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PROSPECT PARK</u>					c. LENGTH OF STAY IN 1b <u>Life</u>					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PROSPECT PARK (24)</u>														
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <u>RIVERSIDE Rd.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <u>EARL D. CALLIGAN</u>					4. DATE OF DEATH <u>8-3-1957</u>																			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Oct 12 - 1890</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>					11. BIRTHPLACE (State or foreign country) <u>MD.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>									
13. FATHER'S NAME <u>THOMAS CALLIGAN</u>					14. MOTHER'S MAIDEN NAME <u>DINS MORE</u>																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. (If yes, give war or dates of service)					17. INFORMANT <u>LAURA SAVERS</u> Address <u>5707 BELAIR</u>														
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Hit</u>																			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																								
ACTUAL SIGNATURE <u>M.B. Davis</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>8/5/57</u>														
EXAMINER'S NAME (Type) <u>M.B. DAVIS MD</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																			
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>					22b. DATE THEREOF <u>8-6-57</u>					22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND'S</u>					22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>									
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Connelly - Esq. MD.</u>										ADDRESS					24a. REC'D BY REGISTRAR <u>1126</u> DATE <u>8/5/57</u>					24b. REGISTRAR'S SIGNATURE <u>Edith Turley</u>				

BUREAU V. S.

NOV 9 1953

RECEIVED

1
HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the doctor certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08257 CERTIFICATE OF DEATH

08246

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. LENGTH OF STAY IN 1b 17 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hosniece		e. STREET ADDRESS Route 96	
3. NAME OF DECEASED (Type or print) First Middle Last Julia Dickey Carmack		4. DATE OF DEATH Month Day Year Aug. 16 1957	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/1877
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Companion		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Robert Dickey		14. MOTHER'S MAIDEN NAME Cornelia Page Needham	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-34-6049	
17. INFORMANT Admission Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) 10 YRS.		INTERVAL BETWEEN ONSET AND DEATH 1 MONTH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 56 , to Aug. , 19 57 , that I last saw the deceased alive on Aug. 16 , 19 57 , and that death occurred at 3:05 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) Timonium, MD DATE SIGNED 8/16/57			
ACTUAL SIGNATURE William A. Pillsbury		PHYSICIAN'S NAME (Type) WILLIAM A. PILLSBURY	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-19-57	
22c. NAME OF CEMETERY OR CREMATORY Mount Olivet		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co., Inc.		24a. REC'D BY REGISTRAR DATE AUG 20 1957	
24b. REGISTRAR'S SIGNATURE W. H. Smith			

4905 York Road - Balto. 12, Md.

REAU V. S.

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

0824738

Reg. Dist. No.

08258

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson - Balto. 4 Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Stella Maris Hosrice, Towson-Balto. 4 Maryland				d. STREET ADDRESS Knights of Columbus-Cathedral & Madison Streets			
3. NAME OF DECEASED (Type or print) First William Middle Valentine Last Carver				4. DATE OF DEATH Month 8 Day 26 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/10/1870		9. AGE (In years last birthday) yrs. 87	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical Position		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Carver				14. MOTHER'S MAIDEN NAME Elizabeth Daphin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Miss Helen Nottingham 10 E. 33rd. Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive Heart Failure, Acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Congestive Heart Failure, Chronic DUE TO (c) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH Days Months & Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cerebrovascular Disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter cause of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 25 , 19 57 to Aug 26 , 19 57 , that I last saw the deceased alive on Aug 25 , 19 57 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard W. Blide				ADDRESS (Street, city or town, state) DATE SIGNED 7501 York Rd. Baltimore, Md.			
PHYSICIAN'S NAME (Type) Richard W. Blide- M.D.				7501 York Road, Baltimore, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/29/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. W. Means & Son 50571 Calvert St.				24. RECEIVED BY REGISTRAR AUG 29 1957		25. REGISTRAR'S SIGNATURE Markel Gray	

RECEIVED
AUG 29 1954
U.S. AIR FORCE

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1250 Sulphur Spring Rd</u>		d. STREET ADDRESS <u>1250 Sulphur Spring Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>B. Caronaugh</u> Middle <u>B.</u> Last <u>1957</u>		DATE OF DEATH <u>8/15/1957</u> Month <u>8</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1890</u> 9. AGE (in years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> IF UNDER 24 HRS Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (State or foreign country) <u>Lanover, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>John Reynolds</u> 14. MOTHER'S MAIDEN NAME <u>Mary E. Rowles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u> 17. INFORMANT <u>Mrs. Laura G. DeBoy</u> Address <u>1250 Sulphur Spring</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma both breasts</u> DUE TO <u>Extensive carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chr myocardiitis</u> DUE TO <u>hypertension</u> (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7</u> 1942, to <u>Aug 15, 1957</u> , that I last saw the deceased alive on <u>Aug 14, 1947</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5607 main st</u> DATE SIGNED <u>8/16/57</u> ACTUAL SIGNATURE <u>B B B...</u> M.D. <u>Ed H. H...</u> PHYSICIAN'S NAME (Type) <u>B B B...</u> <u>Ed H. H...</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>buried</u>	<u>8/19/57</u>	<u>Wendover Cem</u>	<u>Storrey, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howardson</u> ADDRESS <u>301 E. Hollins St</u>		24a. REC'D BY REGISTRAR <u>AUG 19 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Dr. G. M. K...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08259

CERTIFICATE OF DEATH

08249

Reg. Dist. No.

23

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pikesville		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS Halcyon Road	
3. NAME OF DECEASED (Type or print) First Nettie Middle — Last Cockey		4. DATE OF DEATH Month August Day 20 Year 19 57	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1884
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Parks		14. MOTHER'S MAIDEN NAME Doshia Chalk	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Elmer F. Cockey, Stevenson, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE			
DUE TO (b) DIFFUSE BRONCHOPNEUMONIA			
DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PARKINSONISM			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/14 , 19 57 , to 8/21 , 19 57 , that I last saw the deceased alive on 8/18 , 19 57 , and that death occurred at 10:25 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel P. Scalia		ADDRESS (Street, city or town, state) 1331 REISTERSTOWN ROAD	
PHYSICIAN'S NAME (Type) Samuel P. Scalia, M.D.		DATE SIGNED 8/23/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 24, 1957	
22c. NAME OF CEMETERY OR CREMATORY Poplar Grove Cemetery		22d. LOCATION (City, town, or county) (State) Cockeysville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell - Pikesville, Md		24a. REC'D BY REGISTRAR DATE 8/23/57	
24b. REGISTRAR'S SIGNATURE Dorothy Newell			

DEAD V. S.

AUG 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

CERTIFICATE OF DEATH

Reg. Dist. No.

0825041

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MD b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12 PATAPSCO AVE		d. STREET ADDRESS 12 PATAPSCO AVE	
3. NAME OF DECEASED (Type or print) HARRY R. COHN.		4. DATE OF DEATH 8-27-57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 JUNE, 1888
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHARMACIST		10b. KIND OF BUSINESS OR INDUSTRY DRUG	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-32-4877	
17. INFORMANT GENE VIVIE E. COHN - SAME		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Arterio Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2, 1957 to Aug 27, 1957 , that I last saw the deceased alive on Aug 27, 1957 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel J. Shanker M.D. 3479 Liberty Pkwy		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/31	
22c. NAME OF CEMETERY OR CREMATORY DAK LAWN		22d. LOCATION (City, town, or county) (State) BALTO. CO., MD	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Brady ADDRESS Dundalk, Md.		24. REG'D BY REGISTRAR AUG 30 1957 DATE	
25. REGISTRAR'S SIGNATURE Wm. Kelly			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 in this certificate, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 30 1957

RECEIVED

08260

CERTIFICATE OF DEATH

08251
Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institutional Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 74 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
f. STREET ADDRESS 2818 GANLEY DRIVE				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THOMAS		First A.		Middle COLE		Last	
4. DATE OF DEATH Month AUGUST		Day 10		Year 19 57			
5. SEX MALE	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-2-89		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STREET CLEANER		10b. KIND OF BUSINESS OR INDUSTRY for Baltimore City		11. BIRTHPLACE (State or foreign country) BALTIMORE CO., MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH COLE				14. MOTHER'S MAIDEN NAME ELIZABETH Willalea			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-1		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) POST OPERATIVE STATUS-ILEO-TRANSVERSE COLOSTOMY DUE TO REGIONAL ILEITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS UNKNOWN							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DEHISCENCE OF ABDOMINAL WOUND - 6-6-57						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from May 28 19 57 to August 10 19 57 and that death occurred at 6:02 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 8-10-57							
ACTUAL SIGNATURE T. Lawrence Fleisher		NAME (Type) T. LAWRENCE FLEISHER M.D. VAH, FORT HOWARD, MARYLAND 8-10-57					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/13/57		22c. NAME OF CEMETERY OR CREMATORY NEW CATHADRAL CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Cowan & Son		ADDRESS 9012 Hollins St.		24a. REC'D BY REGISTRAR Aug 12 1957		24b. REGISTRAR'S SIGNATURE Dawson L. Harley	
HOLLINS & POPPLETON STS., BALTIMORE, MD.							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

19 12 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08261

CERTIFICATE OF DEATH

Reg. Dist. No.

082524

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point			
c. LENGTH OF STAY IN 1b 35 Yrs				/ d. STREET ADDRESS Sparrows Pt. Rt. 10, Box 320 A			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sparrows Pt. Rt. 10 Box 320A				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Beulah Middle H. Last Collins				4. DATE OF DEATH Month Aug. Day 15, Year 19 57			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1895		9. AGE (In years last birthday) yrs 61	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edgar Hannon				14. MOTHER'S MAIDEN NAME Betty Bowers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO			
				17. INFORMANT Mrs Rowena Hammond, Sparrows Pt. Box 320 A.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO Carcinoma of Breast, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 3 yrs. 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1, 1957 , to Aug 15, 1957 , that I last saw the deceased alive on Aug 13, 1957 , and that death occurred at 8 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. H. Wain M.D.				ADDRESS (Street, city or town, state) 520 D St. S. P. 19			
DATE SIGNED 8/16/57							
PHYSICIAN'S NAME (Type) ROGER G WINDSOR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 17/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave				24a. REC'D BY REGISTRAR DATE 8/20/57		24b. REGISTRAR'S SIGNATURE L. L. L. L.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JG 1957

RECEIVED

08262

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>Two weeks 1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Armacost Nursing Home, Shermans & Register</u>				d. STREET ADDRESS <u>1547 Kings way Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Lee</u> Last <u>Combs Sr.</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1886</u>	9. AGE (In years last birthday) <u>71</u> yrs	IF UNDER 1 YEAR Months <u>1</u> Days <u>3</u> Hours <u>22</u> Min <u>30</u>		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturer of Uniforms</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nurses Uniform Co</u>		11. BIRTHPLACE (State or foreign country) <u>St. Marys County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>George W. Combs</u>				14. MOTHER'S MAIDEN NAME <u>Martha Fowler Combs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-22-8612</u>		17. INFORMANT <u>Joseph L Combs Jr</u> Address <u>5529 Miller Rd Balto 12 Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4-5 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>57</u> , to <u>Aug 29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 29</u> , 19 <u>57</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald W. Mintzer</u>		M.D. <u>3009 EVERGREEN AVE</u>		DATE SIGNED <u>Aug 30 1957</u>		ADDRESS (Street, city or town, state) <u>BALTIMORE 14 Md</u>	
PHYSICIAN'S NAME (Type) <u>DONALD W. MINTZER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND PK</u>		22d. LOCATION (City, town or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEO H LEIMBACH</u>		ADDRESS <u>525 LYNDSBURG ST</u>		24a. REC'D BY REGISTRAR <u>3</u>		24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>	

RECEIVED

3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for a burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 082543										
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY BALTO					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE			c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4136 Lincoln Ave.					d. STREET ADDRESS 4136 Lincoln Av			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ROYAL Middle HENRY Last COMES					4. DATE OF DEATH Month August Day 26 Year 19 57					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 14, 1897		9. AGE (In years last birthday) 59 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Comes					14. MOTHER'S MAIDEN NAME Susan J. Chenoweth					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-30-3273		17. Physician			Address 4136 Lincoln Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic coronary artery disease DUE TO (c) undet PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH, approx 3hrs										
MEDICAL CERTIFICATION										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE John C. Hyle					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
NAME (Type) John C Hyle					8-26-57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 29/57		22c. NAME OF CEMETERY OR CREMATORY Parkwood			22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Lorinda Funeral Home					ADDRESS 7401 Belair Rd		24a. REC'D BY REGISTRAR ANG 20 10		24b. REGISTRAR'S SIGNATURE Mrs. A. L. Reynolds	

BUREAU V. S.

AUG 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08236

CERTIFICATE OF DEATH

Reg. Dist. No.

0825547

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>			
c. LENGTH OF STAY IN lb <u>9 Yrs.</u>				d. STREET ADDRESS <u>4322 Ridge Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>4322 Ridge Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William E. Council</u>				DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 3, 1878</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Lucy P. Council</u> Address <u>4322 Ridge Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Essential Hypertension</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Nov. 25, 1955</u> , to <u>Aug. 1, 1957</u> , that I last saw the deceased alive on <u>12/15/57</u> , 19____, and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. P. Potter</u> M.D.				ADDRESS (Street, city or town, state) <u>2436 Washington Blvd Baltimore 30 Md</u>			
PHYSICIAN'S NAME (Type) <u>C. P. Potter</u>				DATE SIGNED <u>Aug 5 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 3, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge</u>		22d. LOCATION (City, town, or county) (State) <u>Dorsey Howard, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrase, Inc 1328 Sulphur Spring Rd.</u>				24a. REC'D BY REGISTRAR <u>AUG 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. G. M. Kuffner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

1917

RECEIVED

08264

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE MD. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 7 yrs.	
d. NAME OF HOSPITAL (If in hospital) or INSTITUTE OR INSTITUTION ON 1002 N. Rolling Road Shady Nook Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First M. Middle Elsie Last Crew		4. DATE OF DEATH Month August Day 2 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1887
9. AGE (In years last birthday) 70 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Newton Enos	
14. MOTHER'S MAIDEN NAME Alice----		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Clarence Stoner, Niece, 603 Plymouth Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Discompensation 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chs. Hypertensive Cardio-Vascular Disease DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 wks. 20 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 7, 1950 , to August 2, 1957 , that I last saw the deceased alive on August 1, 1957 , and that death occurred at 8:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6209 Frederick Ave. Baltimore 28, Md. DATE SIGNED 8-3-57			
ACTUAL SIGNATURE Wilmer K. Gallagher		M.D. 6209 Frederick Ave. Baltimore 28, Md.	
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher		ADDRESS Baltimore 28, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 5/57	22c. NAME OF CEMETERY OR CREMATORY London Park	22d. LOCATION (City, town, or county) (State) Baltimore 29, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson		24. REC'D BY REGISTRAR Aug 7 57	
25. REGISTRAR'S SIGNATURE W. J. ...		26. REGISTRAR'S SIGNATURE W. J. ...	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1. The funeral director, may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 7 1957

BUREAU V. E.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. **TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08265

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film 6219 8-14-57 et

08257

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MD.		c. LENGTH OF STAY IN 1b D O A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Hospital				d. STREET ADDRESS 3329 Beech Ave.			
3. NAME OF DECEASED (Type or print) First ANDREW Middle JOSEPH Last CUNNINGHAM				4. DATE OF DEATH Month August Day 5 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 1, 1887		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) CARPET WEAVER		10b. KIND OF BUSINESS OR INDUSTRY RUG CO.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Cunningham				14. MOTHER'S MAIDEN NAME Harrorah O'Meara			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217 12 7278		17. INFORMANT Address Mrs. M. M. Coughlin, 4600 Pall Mall Rd. Balto. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443x IMMEDIATE CAUSE (a) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (b) 443x (c) 443x DUE TO cause lost.						INTERVAL BETWEEN ONSET AND DEATH 8 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> ONE		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. DAVIS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) M. B. DAVIS, M. D.		DATE SIGNED 8/5/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 8, 1957		22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE L. Vernon Lemmon				ADDRESS 4611 Park Heights, Balto.		24a. REC'D BY REGISTRAR Aug 7 1957	
				24b. REGISTRAR'S SIGNATURE Dawson			

✓

1957

BUREAU V. S.

AUG 7 1957

RECEIVED

08266

CERTIFICATE OF DEATH

08258

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 216 Stevenson Lane		d. STREET ADDRESS 216 Stevenson Lane	
3. NAME OF DECEASED (Type or print) First DONALD Middle H. Last DASHIELL		4. DATE OF DEATH Month Aug. Day 25 , Year 57	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 18, 1917
9. AGE (In years last birthday) 40 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Paul H. Dashiell		14. MOTHER'S MAIDEN NAME Nellie Lessner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes World War II		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Gloria Dashiell -216 Stevenson Lane		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Left Lung 123X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 1 , 19 57 , to Aug 25 , 19 57 , that I last saw the deceased alive on Aug 25 , 19 57 , and that death occurred at 4:30 PM from the causes and on the date stated above.			
ACTUAL SIGNATURE Laurence C. Post M.D.		ADDRESS (Street, city or town, state) 6805 YORK RD Baltimore 12 Md.	
PHYSICIAN'S NAME (Type) LAURENCE C. Post		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/28/57	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	22d. LOCATION (City, town, or county) (State) Woodlawn, Md.
23. FUNERAL DIRECTOR'S SIGNATURE John G. Lickner & Sons		24a. REC'D BY REGISTRAR 1957	
ADDRESS Balto 17th		24b. REGISTRAR'S SIGNATURE Michel Grey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 20 1907

RECEIVED

08267

CERTIFICATE OF DEATH

Reg. Dist. No.

39

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o STATE Md b. COUNTY Balto	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION York Rd		d. STREET ADDRESS York Rd.	
3. NAME OF DECEASED (Type or print) First Sarah Middle Frances Last Daughton		4. DATE OF DEATH Month August Day 17 Year 1957	
5. SEX Female	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 Sept 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Richmond Va		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Causion		14. MOTHER'S MAIDEN NAME Rebecca Veney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Husband	
17. INFORMANT Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac-decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic cardiovascular disease 3yrs DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 14y
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1957 to Aug 1957 , that I last saw the deceased alive on 17 August, 1957 , and that death occurred at 7:15 M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) Cockeysville Md		DATE SIGNED 17 Aug 57	
ACTUAL SIGNATURE Walter T. Kees		M.D. Cockeysville Md	
PHYSICIAN'S NAME (Type) Walter T. Kees			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-20-57	22c. NAME OF CEMETERY OR CREMATORY Stevenson Cem.	22d. LOCATION (City, town, or county) (State) Sparks Md.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. A. Jackson		ADDRESS Funeral Home Inc	
24a. REC'D BY REGISTRAR AUG 20 1957		24b. REGISTRAR'S SIGNATURE Edg. Branch	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 29 1957

RECEIVED

08268

CERTIFICATE OF DEATH

Reg. Dist. No.

08268

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 3mtnsl4dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena, Md.	
3. NAME OF DECEASED (Type or print) First Middle Last Ida EUGENIE P. Davis		4. DATE OF DEATH Month Day Year Aug. 4 19 57	
5 SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1892
9 AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Burggraf		14. MOTHER'S MAIDEN NAME Anna A. Wagner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-01-3448	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) AORTITIS DUE TO (c) LUES			INTERVAL BETWEEN ONSET AND DEATH 7/15/57 8/3/57
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 3 , 19 57 , to AUGUST 3 , 19 57 , that I last saw the deceased alive on AUGUST 3 , 19 57 , and that death occurred at 10:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE David E. Edwards M.D.		SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) DAVID E. EDWARDS Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/6/57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tichenor		24a. REC'D BY REGISTRAR DATE Aug 9 57	
ADDRESS Longwood Rd. Annapolis		24b. REGISTRAR'S SIGNATURE David E. Edwards	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 1957

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2011 Russell Ave.		d. STREET ADDRESS 2011 Russell Ave.	
3. NAME OF DECEASED (Type or print) First LEDIA Middle F. Last DEATEL		4. DATE OF DEATH Month Aug. Day 29, Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1882 Apr. 28, 1881
9. AGE (In years last birthday) 75 76 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME August Haupt	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.	
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Charles A. Deatel - 2011 Russell Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/1 1957, to 8/29 1957, that I last saw the deceased alive on 8/1 1957, and that death occurred at 11 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6410 Windsor Mill Rd DATE SIGNED ACTUAL SIGNATURE Milton Schlenoff M.D. PHYSICIAN'S NAME (Type) Milton Schlenoff			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/3/57	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.	22d. LOCATION (City, town, or county) (State) Balto., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Stm. J. Vickers		24a. REC'D BY REGISTRAR DATE 9/3/57	24b. REGISTRAR'S SIGNATURE Dr. Jm. Martin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 2 1955

REAU V. S.

08262
Reg. Dist. No.

VS 15M (4)
A1M 9/55

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croftersville, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1250 Sulphur Spring Rd</u>	
3. NAME OF DECEASED (Type or print) <u>DEBOY, PETER</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>18</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16 1876</u>
9. AGE (In years last birthday) <u>81</u>		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>2</u> Hours <u>0</u> Min <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Ferdinand DeBoy</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth DeBoy</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>217-20-1944</u>	
17. INFORMANT <u>Mrs Elizabeth DeBoy</u>		18. ADDRESS <u>1250 Sulphur Spring Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>472.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 1957</u> to <u>8/18</u> , 1957, that I last saw the deceased alive on <u>8/18</u> , 1957, and that death occurred at <u>9 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert J. Levickas</u>		DATE SIGNED <u>8/10/57</u>	
PHYSICIAN'S NAME (Type) <u>Herbert J. Levickas</u>		ADDRESS (Street, city or town, state) <u>5305 East Drive Baltimore - 27 Md</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. NAME OF CEMETERY OR CREMATORY <u>New Catholic</u>	
22c. DATE THEREOF <u>Aug 20 1957</u>		22d. LOCATION (City, town, or county) (State) <u>Fredesburg, A. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Ray</u>		ADDRESS <u>5646 Carroll Ave</u>	
24a. REC'D BY REGISTRAR <u>Dr. G. M. Kupper</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. G. M. Kupper</u>	

BUREAU V. S.

1957

RECEIVED

08270

CERTIFICATE OF DEATH

08263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 1029 Myrtle Avenue		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MATTHEW (ALSO: Matthew Dowell) Last DOWELL		4. DATE OF DEATH Month August Day 6 Year 19 57	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/97
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseman		10b. KIND OF BUSINESS OR INDUSTRY Hotel	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anna Dowell		14. MOTHER'S MAIDEN NAME Jane (MN: Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 212-05-4548	
17. INFORMANT Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NECROTIC HEMORRHAGIC LESION OF THE PALATE AND PHARYNX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO CHRONIC LYMPHOCYTIC LEUKEMIA DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 2 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 26 19 57 , to August 6 19 57 , and that death occurred at 5:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Chen Wei Lan		ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 8/8/57	
PHYSICIAN'S NAME (Type) CHEN WEI LAN, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-9-57	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. SIGNATURE OF REGISTRAR Charles R. Law		24a. REC'D BY REGISTRAR AUG 9 1957	
24b. REGISTRAR'S SIGNATURE Dawson L. Farley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be filed with the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 7 1957

BUREAU V. 2

08271

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Co.		d. STREET ADDRESS 76 River Road	
3. NAME OF DECEASED (Type or print) First ERNEST Middle EDWIN Last EAGLE		4. DATE OF DEATH Month August Day 7 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 4, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR: Months 1 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired-inn worker		10b. KIND OF BUSINESS OR INDUSTRY Arundel Corp.	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Thomas Eagle	
14. MOTHER'S MAIDEN NAME Rosalie Payne		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Rosalie Baacke, 713 Brookwood Rd. Zone 29	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Congestion - Ribility DUE TO (c) Acute Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 3 3 4	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Prostate Gland		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 1, 1957 to August 7, 1957 that I last saw the deceased alive on August 6, 1957 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Nelson McKay		M.D. 6014 Edmonson Ave Baltimore Md 8/8/57	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/10/57	22c. NAME OF CEMETERY OR CREMATORY Oak Lawn	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		24a. REC'D BY REGISTRAR ROBERT	
ADDRESS Schimunek Funeral Home 3331 Brehms Lane		24b. REGISTRAR'S SIGNATURE W. A. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 12 1957
BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08272

CERTIFICATE OF DEATH

08265

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4, c. LENGTH OF STAY IN 1b 2½ yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 203 Baltimore Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admn.sion) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4, d. STREET ADDRESS 203 Baltimore Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARNOLD Middle JOHN Last EICHOLTZ		4. DATE OF DEATH Month AUGUST Day 26 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-1901
9. AGE (In years last birthday) 57 yrs		10. IF UNDER 1 YEAR Months 2 Days 26 Hours 57 Min	11. IF UNDER 24 HRS. Months 2 Days 26 Hours 57 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman		10b. KIND OF BUSINESS OR INDUSTRY Balto.Co.Hwys.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Eicholtz		14. MOTHER'S MAIDEN NAME Elizabeth Mumma	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-16-9312	
17. INFORMANT Mary C. Eicholtz		Address Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 162X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMATOSIS DUE TO (c) BRONCHOGENIC CARCINOMA WITH METASTASES		INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 1 YEAR 18 MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APRIL 15, 1957 to AUGUST 26, 1957 , that I last saw the deceased alive on AUGUST 24, 1957 , and that death occurred at 1:50 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald L. Somerville		ADDRESS (Street, city or town, state) 25 West Pennsylvania Avenue	
PHYSICIAN'S NAME (Type) DONALD L. SOMERVILLE		DATE SIGNED 8/26/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-29-57	
22c. NAME OF CEMETERY OR CREMATORY St. John's Methodist		22d. LOCATION (City, town, or county) (State) Long Green, Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott Brooks		24a. REC'D BY REGISTRAR Aug. 27, 1957	
ADDRESS 622 York Rd. Towson 4, Md		24b. REGISTRAR'S SIGNATURE Mabel C. Gray	

RECEIVED

AUG 28 1957

BUREAU OF

08273

CERTIFICATE OF DEATH

08266

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>md.</u> b. COUNTY <u>Essex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 yr.</u>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>1630 Hopewell Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Isabella Epps</u>		4. DATE OF DEATH Month Day Year <u>Aug. 4 1957</u>	
5. SEX <u>Female</u>	6 COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Feb. 18 1892</u>
9. AGE (In years last birthday) <u>65</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jasper Collier</u>		14. MOTHER'S MAIDEN NAME <u>Julia Ann?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>William Epps</u>	
17. INFORMANT <u>William Epps</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia, coma</u> DUE TO (b) <u>Chronic glomerulonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Heart failure. Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 years</u> <u>10 days - severe</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 27, 1955</u> to <u>August 4, 1957</u> , that I last saw the deceased alive on <u>August 4, 1957</u> , and that death occurred at <u>5:50 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eugene C. Baumann</u>		DATE SIGNED <u>8-6-57</u>	
PHYSICIAN'S NAME (Type) <u>Eugene C. Baumann, M.D.</u>		ADDRESS (Street, city or town, state) <u>413 Eastern Ave., Essex, Md.</u>	
22a. BURIAL, CREMATION, REMOVA. (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 8/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Ad. Crutcher Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Josiah P. Ellickson</u>		24. REC'D BY REGISTRAR <u>Edith Turley</u>	
ADDRESS <u>16297 Caroline St.</u>		DATE <u>AUG 9 1957</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 9 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08274

CERTIFICATE OF DEATH

08267

Reg. Dist. No.

40

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 1038 Stevens Rd.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 White Marsh	
3. NAME OF DECEASED (Type or print) First John Middle James Last Farrell Sr.		4. DATE OF DEATH Month August Day 4 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 28, 1905
9. AGE (In years last birthday) yrs. 52		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meter Reader		10b. KIND OF BUSINESS OR INDUSTRY Gas & Elec. Co.	
11. BIRTHPLACE (State or foreign country) Nova Scotia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Farrell		14. MOTHER'S MAIDEN NAME Alma Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-05-4852	
17. INFORMANT John J. Farrell Jr.		Address Box 1038 Stevens Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO (b) metastatic carcinoma DUE TO (c) Carcinoma of large bowel Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 week less than 2 yrs 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/27 , 19 57 , to 8/5 , 19 57 , that I last saw the deceased alive on 8/4 , 19 57 , and that death occurred at 6:45 a.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Platt		DATE SIGNED 434 Eastern Ave	
PHYSICIAN'S NAME (Type) J. PLATT, M.D.		Essey, m.d.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 7, 1957	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		24. REC'D BY REGISTRAR Aug 6 1957	
ADDRESS 7401 Belair Rd.		25. REGISTRAR'S SIGNATURE Dr. Nathan Kennedy	

MAU V. S.

UG 1977

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

08275

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 312 Mason Court	
3. NAME OF DECEASED (Type or print) (ALSO: CLYDE BUSH) CLAUDE W. FAWBUSH		4. DATE OF DEATH Month August Day 3 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/23/78
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours M'n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Road Construction	
11. BIRTHPLACE (State or foreign country) Churchill, Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Fawbush		14. MOTHER'S MAIDEN NAME Joanna Arnold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes		16. SOCIAL SECURITY NO 234-12-6598	
17. INFORMANT Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY ARTERIOSCLEROSIS SEVERE WITH OLD MYOCARDIAL INFARCTIONS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) PULMONARY CONGESTION AND EDEMA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 7 YEARS UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 10 , 19 57 , to August 3 , 19 57 , and that death occurred at 11:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED 8/4/57 ACTUAL SIGNATURE Chien Wei Lan M.D. PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D. Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-8-57	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE William Cook-Blight, Inc.		24a. REC'D BY REGISTRAR UG 9 1957	
24b. REGISTRAR'S SIGNATURE James L. Farley			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 9 1937

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08276

08263

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson			
c. LENGTH OF STAY IN 1b 3 years							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1001 W. Joppa Road				d. STREET ADDRESS 1001 West Joppa Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Assumpta (Feehly)				4. DATE OF DEATH Month Day Year Aug 23 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 24, 1892		9. AGE (In years, lost birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun		10b. KIND OF BUSINESS OR INDUSTRY Convent		11. BIRTHPLACE (State or foreign country) Drinane, Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Feehly				14. MOTHER'S MAIDEN NAME Mary Tulley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Convent Records, 1001 W. Joppa Rd. Towson, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral haemorrhage 931X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential Hypertension DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH Minutes Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/23 , 19 57 , to 8/23 , 19 57 , that I last saw the deceased alive on Didn't , 19____, and that death occurred at 9:00 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard W. Blide				ADDRESS (Street, city or town, state) 7501 York Rd. Baltimore, Md.			
PHYSICIAN'S NAME (Type) Richard W. Blide				DATE SIGNED 7501 York Road, Baltimore, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 26, 1957		22c. NAME OF CEMETERY OR CREMATORY Convent Cemetery		22d. LOCATION (City, town, or county) (State) 1001 W. Joppa Rd. Towson, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Vernon Lennon				ADDRESS 4611 Park Hgts. Balto. Md.		24a. REGD BY REGISTRAR Aug 26 1957	
				24b. REGISTRAR'S SIGNATURE Mark Gray			

BUREAU V. S.

JUN 1 1957

RECEIVED

08277

CERTIFICATE OF DEATH

08270

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines		d. STREET ADDRESS 4807 Belle Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATIE		Middle FINK		Last		4. DATE OF DEATH Month August 24	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1883	
9. AGE (In years last birthday) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Solomon Crook		14. MOTHER'S MAIDEN NAME Rosa B. Miller		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ida M. Peltz		Address 4807 Belle Avenue		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). ACUTE RENAL FAILURE 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). H. A. S. C. X D. DUE TO (c).		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 10, 1956 , to Aug 24, 1957 , that I last saw the deceased alive on July 28, 1957 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 7013 Liberty Road		DATE SIGNED August 25, 1957			
ACTUAL SIGNATURE Leonard H. Golombek		M.D.		PHYSICIAN'S NAME (Type) Leonard H. Golombek		7013 Liberty Road	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 25, 1957		22c. NAME OF CEMETERY OR CREMATORY Anshe Emunah		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Sal Spindler		ADDRESS 1124-26 W. North Ave		24a. REC'D BY REGISTRAR DATE AUG 26 '57		24b. REGISTRAR'S SIGNATURE Art Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 23 1957

BUREAU V. S.

08278

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08271

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto. City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Caton Ridge Nursing Home, Harlem Lane		d. STREET ADDRESS 3731 Raspe Ave.	
3. NAME OF DECEASED (Type or print) Margaret (Maggie) B. Ford		4. DATE OF DEATH Aug. 19 1957	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 25, 1866
9. AGE (In years last birthday) 91 yrs.		10. F UNDER 1 YEAR <input type="checkbox"/> F UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Somerset Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John H. Mc Dorman		14. MOTHER'S MAIDEN NAME Annie Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. May E. Ford		Address 3407 Lake Montebello Terrace.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Cardiovascular disease, Senility Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture left femur Accident DUE TO Pinning operation July 24, 1957 St. Agnes Hosp. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Fell on floor, caught foot in her old bath robe	
20c. TIME OF INJURY Month, Day, Year 6:00 p.m. July 17-57	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nursing Home	20f. (City or town) (County) (State) Catonsville Balto. Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Geo. S. M. Kieffer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/57	22c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery
		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 5305 Harford Road #14	24a. REC'D BY REGISTRAR AUG 21 '57
		24b. REGISTRAR'S SIGNATURE Al Leach	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

AUG 21 1967

BUREAU V. S.

08279

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0827238

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON	
d. NAME OF HOSPITAL (If not in hospital, give street address) 8370 HILLENDALE RD		d. STREET ADDRESS 8370 HILLENDALE RD	
3. NAME OF DECEASED (Type or print) FRANCES E. FRANTZ		4. DATE OF DEATH AUG. 30 1957	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 22 1914
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT	
11. BIRTHPLACE (State or foreign country) MINERSVILLE PA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PETER SESINAVAGE		14. MOTHER'S MAIDEN NAME FRANCES DANIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 180-01-7623	
17. INFORMANT HARRY J. FRANTZ		Address 8370 HILLENDALE RD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastases 170 DUE TO CARCINOMA Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Had radiol Breast Operation 8 years ago			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1957 , 19____, to Aug , 19 57 , that I last saw the deceased alive on July 27 , 19 57 , and that death occurred at 4 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Denis J. McGrath		ADDRESS (Street, city or town, state) 8358 Loch Raven Blvd	
PHYSICIAN'S NAME (Type) DENIS J. McGRATH		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF SEPT 25 1957	22c. NAME OF CEMETERY OR CREMATORY PARKWOOD	22d. LOCATION (City, town, or county) (State) TAYLOR AVE MD
23. FUNERAL DIRECTOR'S SIGNATURE Ruppel Bros 7110 BELAIR RD		24a. REC'D BY REGISTRAR SEP 3 1957	
ADDRESS 7110 BELAIR RD		24b. REGISTRAR'S SIGNATURE John Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of 4, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08280
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

08273

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MD. c. LENGTH OF STAY IN 1b 2 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 7814 St. Gregory Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LUTHER Middle W. Last FRAZIER		4. DATE OF DEATH Month August Day 3 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 8, 1894
9. AGE (In years last birthday) 63 yrs		IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chipper & Caulker		10b. KIND OF BUSINESS OR INDUSTRY Ship Yard	
11. BIRTHPLACE (State or foreign country) Elkton, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Chadrick Frazier		14. MOTHER'S MAIDEN NAME Ella Jane Shifflet	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give way or date of service) WW I		16. SOCIAL SECURITY NO 233-18-4861	
17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 Hours 3 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) OLD CEREBRAL VASCULAR ACCIDENT			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from August 1, 1957 to August 3, 1957 and that death occurred at 7:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 8/3/57			
ACTUAL SIGNATURE Frederick J. Balsam M. D. FREDERICK J. BALSAM, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-7-57	
22c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		22d. LOCATION (City, town, or county) (State) Elkridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm-Cook Blight Funeral Home, 6009 Harford Rd.		24a. REC'D BY REGISTRAR AUG 9 1957	
24b. REGISTRAR'S SIGNATURE Dawson L. Farley			

BUREAU V. S.

AUG 7 1907

RECEIVED

08281

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN lb x2 Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13 Madeline Ave.		d. STREET ADDRESS 13 Madeline Ave.	
3. NAME OF DECEASED (Type or print) First Charles Middle H. Last Freeman Sr.		4. DATE OF DEATH Month August Day 19 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 7, 1880
9. AGE (In years last birthday) yrs 77		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting	11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Edward Freeman	
14. MOTHER'S MAIDEN NAME Anna Vogt		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 219-01-6756		17. INFORMANT Mrs. Margaret C. Freeman Address 13 Madeline Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage DUE TO Atherosclerosis & Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) old Hemiplegia. DUE TO (c) None		INTERVAL BETWEEN ONSET AND DEATH 24 hour 4+ yr 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 18, 1957 , to Aug 19, 1957 , that I last saw the deceased alive on Aug 19, 1957 , and that death occurred at 8:10 PM from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 9005 Hartford Rd. BALTO., 14 Md.	
ACTUAL SIGNATURE Frank T. Kasik Jr. M.D.		DATE SIGNED 8/19/57	
PHYSICIAN'S NAME (Type) FRANK T. KASIK, JR.		BALTO., 14 Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 22, 1957	22c. NAME OF CEMETERY OR CREMATORY Oaklawn	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lanahan Funeral Home		24a. REC'D BY REGISTRAR 7401 Belair Rd.	24b. REGISTRAR'S SIGNATURE AUG 21 1957 Mrs. L. L. Rife

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 7 Ruth & Veronica Ave.		d. STREET ADDRESS / Box 7 Ruth & Veronica Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph John Gaydosh		4. DATE OF DEATH Month August Day 4 Year 1957		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19 1882	
9. AGE (In years last birthday) 75 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Budapest Hungary		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 213-07-2801	
17. INFORMANT Michael Gaydosh		Address Box 7 Ruth & Voroca Ave.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] 213-07-2801	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 mos.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cong. Heart Failure, Ant. Sch. Heart Disease	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. fl. Month 19 Day 19 Year 1957 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Jan 1, 1952 to Aug 4, 1957 , that I last saw the deceased alive on Aug 3, 1957 , and that death occurred at 3 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE R. G. WILYUSOIR		ADDRESS (Street, city or town, state) 4013 Chester St. Balto. Md.		DATE SIGNED 8-15-57	
PHYSICIAN'S NAME (Type) R. G. WILYUSOIR		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Aug 8/57		22b. DATE THEREOF Aug 8/57	
22c. NAME OF CEMETERY OR CREMATORY Sacred Heart		22d. LOCATION (City, town, or county) Baltimore		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Willeg		ADDRESS 4013 Chester St. Balto. Md.		24a. REC'D. BY REGISTRAR W. G. 1957	
24b. REGISTRAR'S SIGNATURE W. G. 1957		24c. REGISTRAR'S SIGNATURE W. G. 1957		24d. REGISTRAR'S SIGNATURE W. G. 1957	

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08283

CERTIFICATE OF DEATH

Reg. Dist. No. 08276 43

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kenwood Overlea</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6 McCormick Ave</u>				d. STREET ADDRESS <u>6 McCormick Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>C. Gieseler</u> Last				4. DATE OF DEATH Month <u>Aug</u> Day <u>3</u> Year <u>1957</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31 1886</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Gieseler</u>				14. MOTHER'S MAIDEN NAME <u>Carlton or Caroline Spangenberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>216093533</u>			
17. INFORMANT <u>Helen Gieseler</u>				Address <u>6 McCormick Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhagic, bilateral</u> <u>12x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>April 19, 1949</u> to <u>Aug. 3, 1957</u> , that I last saw the deceased alive on <u>August 3, 1957</u> , and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Adam C. Swiss</u>				M.D. <u>622 Belair Road</u> DATE SIGNED <u>Aug. 5, 1957</u>			
PHYSICIAN'S NAME (Type) <u>Adam C. Swiss</u>				<u>Balto U. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Eastern Ave Rd. Balto. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Doppel Bros. 7110 Belair Rd.</u>				24a. REC'D BY REGISTRAR <u>Aug 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. A. L. Buford</u>	

BUREAU V. S.

19 6 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G219 8-26-57 et

CERTIFICATE OF DEATH

08284

Reg. Dist. No.

08277

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY Unknown	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Recedo Knoll		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Jane Last Giles		4. DATE OF DEATH Month August Day 15 Year 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?
9. AGE (In years last birthday) 96 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Frank Giles Address 4005 Kennington Ave. Richmond, Va.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac failure + a. d. b. DUE TO Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility (c) Senility	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 27 19 57 to Aug 15 19 57 , that I last saw the deceased alive on Aug 15 19 57 , and that death occurred at 8:12 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12470 West Blvd DATE SIGNED Aug 15 57			
ACTUAL SIGNATURE E. M. Kieffer M.D.		PHYSICIAN'S NAME (Type) C. E. O. S. M. KIEFFER M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried	22b. DATE THEREOF 8-17-57	22c. NAME OF CEMETERY OR CREMATORY Cathedral	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home Catonsville, Md. ADDRESS		24a. REC'D BY REGISTRAR AUG 19 57	24b. REGISTRAR'S SIGNATURE Arthur Smith

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Affix this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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AUG 19 1957

BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08238

CERTIFICATE OF DEATH

08278 *45*

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Arbutus</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4315 Wilkens Ave</u>		d. STREET ADDRESS <u>14315 Wilkens Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOTTIE VIRGINIA GIST</u>		4. DATE OF DEATH Month Day Year <u>Aug. 14, 1957</u> <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 23, 1874</u>
9. AGE (In years last birthday) <u>82</u> yrs		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Grove</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Flemming</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Nancy Lindsay</u>		Address <u>4315 Wilkens Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Serious</u> DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>Undet</u> <u>Undet</u> </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardiovascular disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home; farm; factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> <u>1951</u> , to <u>Aug. 14</u> <u>1957</u> , that I last saw the deceased alive on <u>Aug 14</u> <u>1957</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1264 Francis Ave Balto</u> DATE SIGNED <u>27-8-15-57</u>			
ACTUAL SIGNATURE <u>A. Bradley Daugharthy, M.D.</u> PHYSICIAN'S NAME (Type) <u>A. Bradley Daugharthy, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>August 17, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Morgan Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Woodbine, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Ave</u>	
24a. REC'D BY REGISTRAR <u>Aug 16 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. L. M. Kieffer</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08285

CERTIFICATE OF DEATH

08279

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Corbett Rd</u>		d. STREET ADDRESS <u>Corbett Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Frederick</u> Middle <u>Russell</u> Last <u>Gokey</u>		4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 Dec 1903</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>3</u> Hours <u>13</u> Min <u>53</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Engineer Western Electric</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York N.Y.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Frederick Gokey</u>		14. MOTHER'S MAIDEN NAME <u>Grace Irene Wheatley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>215-03-9573</u>	
17. INFORMANT <u>wife</u>		Address <u>Monkton MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO <u>Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u> <u>11 yrs</u> <u>11 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 49</u> , 19 <u>57</u> , to <u>Aug 57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>July 18</u> , 19 <u>57</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter T. Kees</u>		DATE SIGNED <u>13 Aug 57</u>	
PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>		ADDRESS <u>Cochesville Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>8/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Franklin, New Hampshire</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker</u>		24a. REC'D BY REGISTRAR <u>Aug 14 '57</u>	
ADDRESS <u>North St. Ave</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur</u>	

RECEIVED

AUG 15 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08286

CERTIFICATE OF DEATH

0828038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7819 Shepherd Ave		d. STREET ADDRESS 7819 Shepherd Ave #14	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Minnie Green.		4. DATE OF DEATH Month Aug Day 18 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 10, 1881
9. AGE (In years last birthday) 76 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Frank Shobar		14. MOTHER'S MAIDEN NAME Laura Hemming.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT J. Raymond Green		Address 7819 Shepherd Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1956, to August 1957, that I last saw the deceased alive on August 1957, and that death occurred at 10:00 P.M. , from the causes and on the date stated above			
ACTUAL SIGNATURE J.F. Palmisano		DATE SIGNED Aug 20/57	
PHYSICIAN'S NAME (Type) J.F. PALMISANO		ADDRESS (Street, city or town, state) Baltimore, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug 21, 1957	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Hampden	22d. LOCATION (City, town, or county) (State) 3900 Roland Ave. Balto, Md
23. FUNERAL DIRECTOR'S SIGNATURE Dustin E. Korman		ADDRESS 3818 Roland Ave	
24a. REC'D BY REGISTRAR AUG 23 1957		24b. REGISTRAR'S SIGNATURE D. R. M. Bacon	

BUREAU OF

JUN 23 1957

RECEIVED

08281

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN lb 35 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 19 LIBERTY PKWY.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle HULL Last GRUMMEY		4. DATE OF DEATH 8-28-57 19	
5. SEX FEM.	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 MAY, 1899
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY ————	
11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BENJ. HALL		14. MOTHER'S MAIDEN NAME HANNAH McMANIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. NONE CLIDE GRUMMEY —	
17. INFORMANT Address SAME			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H-S-C-V-DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? Coryn O'Connell - April 1957 - YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1957 to August 1957 that I last saw the deceased alive on 8-27-57, 12, and that death occurred at 6:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE M.B. Davis		DATE SIGNED 8/29/57	
PHYSICIAN'S NAME (Type) M.B. DAVIS MD		ADDRESS (Street, city or town, state) Dundalk, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/31/57	
22c. NAME OF CEMETERY OR CREMATORY MORELAND MEM.		22d. LOCATION (City, town, or county) (State) BALTO. Co. MD	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
Address		24b. REGISTRAR'S SIGNATURE	
Date		Date	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 (b) should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 30 1957

RECEIVED

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08287

Item 9 Filed 10-12-57
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 CERTIFICATE OF DEATH

Reg. Dist. No.

08288

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b 52 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3 Vol-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sheppard and Enoch Pratt Hospital				d. STREET ADDRESS 3701 Menlo Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANCES First		Middle KOHLER		Last GUMP		4. DATE OF DEATH Month August Day 23 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12, 1874		9. AGE (In years last birthday) 82 3/4 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME David Kohler				14. MOTHER'S MAIDEN NAME Jane ----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490-X Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left lobar pneumonia DUE TO (c) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 7 , 19 45 , to August 23 , 19 57 , that I last saw the deceased alive on August 23 , 19 57 , and that death occurred at 8:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED August 24, 1957							
ACTUAL SIGNATURE Harry M. Murdock		M.D. August 24, 1957					
PHYSICIAN'S NAME (Type) Harry M. Murdock, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8-26-57		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE David R. Martin David R. Martin, 1902 Eutaw Place				24a. REC'D BY REGISTRAR AUG 27 1957		24b. REGISTRAR'S SIGNATURE Robert Gump	

RECEIVED

SEP 11 1957

RECEIVED

08288

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto.	
c. LENGTH OF STAY IN 1b 19 Mo.		d. STREET ADDRESS Formerly Of-701 Chapel Gate Lane	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House In The Pines 16 Fustling Ave		15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MaNola Middle F. Last Hayden		4. DATE OF DEATH Month Aug. Day 9 Year 19 57	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1878
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Cornelius Lowry		14. MOTHER'S MAIDEN NAME Laura Fallon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Garnett Hayden, 701 Chapel Gate Lane		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b) Ch. Hypertensive Cardio-Vascular Disease			
DUE TO			
(c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 30, 1957 , to Aug. 9, 1957 , that I last saw the deceased alive on Aug. 9, 1957 , and that death occurred at 5:50 P.M. from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL PHYSICIAN Wilmer K. Gallagher M.D. 6209 Frederick Ave 8/12/57			
PHYSICIAN'S NAME (Type) Wilmer K Gallagher Baltimore, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 12/57	
22c. NAME OF CEMETERY OR CREMATORY Calver Va.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson A		24a. REC'D BY REGISTRAR Aug 14 57	
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 15 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

08289

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08284

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY Balto MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md b. COUNTY Balto			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8629 Belair Rd.				d. STREET ADDRESS 8629 BELAIR RD			
3. NAME OF DECEASED (Type or print) First GEORGE Middle HENRY Last HELLWIG				4. DATE OF DEATH Month August Day 28 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 1, 1889	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Gas station		11. BIRTHPLACE (State or foreign country) Balt. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick Hellwig				14. MOTHER'S MAIDEN NAME Anna Lewis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Carrie W. Hellwig (wife)			Address same
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Gunshot wound left neck --12 gauge shotgun (c), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH undet
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Depression							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Contact type gunshot wound					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Aug 28, 57	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woodland		20f. (City or town) Fullerton	(County) Balto	(State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE John C. Hyle				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 8-2857
EXAMINER'S NAME (Type) John C. Hyle MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 31, 1957	22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) Baltimore, Md.			(State)
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home				ADDRESS 7441 Belair Rd.		24a. REC'D BY REGISTRAR SEP 3 1957	24b. REGISTRAR'S SIGNATURE Mrs. L. H. Hyslop

BUREAU V. S.

23 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS (5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08285

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLE RIVER (ZO)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7 CHANDELLE AVE.</u>		d. STREET ADDRESS <u>17 CHANDELLE AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES AKERY HERNDON</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 15 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 16 1895</u>
9. AGE (in years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NIGHT WATCHMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID M. HERNDON</u>		14. MOTHER'S MAIDEN NAME <u>MARY V. BEARD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>235-12-8565</u>	
17. INFORMANT <u>BESSIE HERNDON</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A-S-C-V- Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
INTERVAL BETWEEN ONSET AND DEATH _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M. B. Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-19-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GARDEN OF FAITH</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Drogoszinski</u>		24a. REC'D BY REGISTRAR <u>AUG 20 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>			

BUREAU V. 81

JUG 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08291

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08286

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sheppard and Enoch Pratt Hospital		d. STREET ADDRESS 302 E. 33 rd St. (18)	
3. NAME OF DECEASED (Type or print) Augusta Louise Herzer		4. DATE OF DEATH Month 8 Day 4 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1881
9. AGE (In years last birthday) 76		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY domestic	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Gustav Herzer		14. MOTHER'S MAIDEN NAME Fredericka I. ? Pfizenmaier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mr. Edw. H. Herzer		Address 7111 Sheffield Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) chronic myocarditis and myocardial degeneration 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) coronary arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ovarian tumor			INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 5 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August 3, 1957 to August 4, 1957 , that I last saw the deceased alive on August 4, 1957 , and that death occurred at 10:20 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sheppard Pratt Hospital, Towson, Md. 8-4-57			
ACTUAL SIGNATURE John L. Carleton		PHYSICIAN'S NAME (Type) John L. Carleton	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 8, 1957	22c. NAME OF CEMETERY OR CREMATORY Louisa Park	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co.		24a. REC'D BY REGISTRAR 1957	
ADDRESS Balto. Md.		24b. REGISTRAR'S SIGNATURE Nobel Gray	

W. A. V. 8

W. A. V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0828738

Reg. Dist. No.

08292

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL* BALTIMORE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3005 Sixth Avenue				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY BALTO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE X d. STREET ADDRESS 3005 Sixth Av Balto 14 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANCIS Middle Mortimer Last HESTER			4. DATE OF DEATH Month August Day 7 Year 19 57				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1911		9. AGE (In years last birthday) 46 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor, Gas & Electric Co		10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Ignatius Mortimer Hester			14. MOTHER'S MAIDEN NAME Julia M. Keller				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Mary Elizabeth Hester, same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive cardiovascular disease (c), stating the underlying cause last. DUE TO					INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs unk		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE John C. Hyle			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8-7-57		
EXAMINER'S NAME (Type) John C Hyle MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/10/1957	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck			ADDRESS 5305 Harford Road #14				
24a. REC'D BY REGISTRAR Aug 12 1957		24b. REGISTRAR'S SIGNATURE Dr. R. M. Bacon					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

AUG 10 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08293

CERTIFICATE OF DEATH

08288 31

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. LENGTH OF STAY IN 1b 20 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1915 Belmont Terrace				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn X2			
f. STREET ADDRESS 1915 Belmont Terrace				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frederick Middle C. Last Hillmeyer				4. DATE OF DEATH Month Aug. Day 2nd. Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Unknown	
9. AGE (In years last birthday) Abt. 81 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>		IF UNDER 24 HRS Hours <input type="checkbox"/> Min <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Motorman				10b. KIND OF BUSINESS OR INDUSTRY Balto. Transit		11. BIRTHPLACE (State or foreign country) Cheyene, Wyoming	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Mr. Hillmeyer				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMY, NAVY, AIR FORCE, OR COAST GUARD? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Span.-Am.				16. SOCIAL SECURITY NO 1915 Belmont Terrace, Woodlawn			
17. INFORMANT Mrs. Henrietta Anderson							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Supremacy of age - 774x DUE TO Malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Feb 1954 to Aug 2, 1957 , that I last saw the deceased alive on Aug 2, 1957 , and that death occurred at 10.05 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE Wm. H. H. Abbott				M.D. 4509 Liberty Heights Ave. 8/5/57			
PHYSICIAN'S NAME (Type) Thomas A. Abbott							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Aug. 6, 1957		Mt. Olive Cemetery		Randallstown, Balto Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Ellis Amoreau				24a. REC'D BY REGISTRAR 1957 24b. REGISTRAR'S SIGNATURE Wm. H. H. Abbott			

RECEIVED

AUG 7 1937

BUREAU V. S.

08294

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore <i>3v:1.4</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in the Pines				d. STREET ADDRESS formerly of 2901 Clifton Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BESSIE Middle HORWITZ Last				4. DATE OF DEATH Month August Day 27 Year 19 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1887		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ellis Kravitsky				14. MOTHER'S MAIDEN NAME Rose ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mr. Sidney Horwitz 3222 Yosemite Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage 5x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive c.v.d. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 1952, to Aug. 27-1957 that I last saw the deceased alive on Aug. 27-1957 , and that death occurred at 7 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Dr. Herman Seidel M.D. 2404 Eutaw Pl. 8/28/57.							
ACTUAL SIGNATURE Dr. Herman Seidel M.D. 2404 Eutaw Place				PHYSICIAN'S NAME (Type) Herman Seidel — 2404 Eutaw Place			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 28, 1957		22c. NAME OF CEMETERY OR CREMATORY Shomra Adas-Tzemech Zedek		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Definison & Sons Inc. 1124-26 W. North Ave.				24a. REC'D BY REGISTRAR DATE AUG 29 57		24b. REGISTRAR'S SIGNATURE Arthur	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 29 1957
BUREAU V. B.

08295

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) Towson (in this place)
TOWN Towson

HOSPITAL OR INSTITUTION OR STREET ADDRESS Eudowood Sanatorium
Towson 4, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY Balto
CITY (If outside corporate limits, write RURAL and give nearest town) Towson 4, Md.
OR TOWN

STREET ADDRESS (If rural give location)
Eudowood Sanatorium

3. NAME OF DECEASED:

(First) Frank (Middle) Howard (Last) Howard
(Type or Print)

4. DATE OF DEATH: (Month) Aug (Day) 21 (Year) 1957

5. SEX:

M

6. COLOR OR RACE:

W

7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify):

SINGLE

8. DATE OF BIRTH:

Aug 21, 1881

9. AGE last birthday:

75 yrs.

If UNDER 1 YEAR If UNDER 24 HRS.
Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

Identical Hospital

10b. KIND OF BUSINESS OR INDUSTRY

Hospital

11. BIRTHPLACE (State or foreign country):

MD

12. CITIZEN OF WHAT COUNTRY:

US

13. FATHER'S NAME:

Frank Howard

14. MOTHER'S MAIDEN NAME:

Ida Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.:

215-32-1917

17. INFORMANT & ADDRESS:

Personal History
Hospital Records, Eudowood Sanatorium

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary Tuberculosis

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) ...

DUE TO

(c)

Interval Between Onset And Death
3972

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☒

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 6/1, 1955, to 8/21, 1957, that I last saw the deceased

alive on 8/21, 1957, and that death occurred at 5:25 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (city, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

Aug. 22, 1957Mabel C. GrayJohn Burns SonsTowson, Md.

MARGIN RESERVED FOR BINDING

RECEIVED

AUG 27 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08296

CERTIFICATE OF DEATH

Reg. Dist. No.

08291

1. PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 15 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5502 Clifton Avenue		d. STREET ADDRESS 5502 Clifton Avenue	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mildred Marguerite Hall Howard		4. DATE OF DEATH Month Day Year August 18, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-18-24
9. AGE (In years last birthday) yrs. 33		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telegraph Operator		10b. KIND OF BUSINESS OR INDUSTRY Western Union	
11. BIRTHPLACE (State or foreign country) Oklahoma City-Oklahoma		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas H. Hall		14. MOTHER'S MAIDEN NAME Grace Reynolds	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-20-4164	
17. INFORMANT Mrs. Juanita Schott, Jacksonville, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) melanoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 12 a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/12 , 19 57 to 8/18 , 19 57 that I last saw the deceased alive on 8/12 , 19 57 , and that death occurred at 6:10 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6410 Windsor Mill DATE SIGNED ACTUAL SIGNATURE Milton Schlenker PHYSICIAN'S NAME (Type) Milton Schlenker			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-18-57	
22c. NAME OF CEMETERY OR CREMATORY Elizabeth, West Virginia		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost ADDRESS 4600 Liberty Hgts. Apts.		24a. REC'D BY REGISTRAR Aug 23 1957 24b. REGISTRAR'S SIGNATURE Dr. J. M. Markley	

BUREAU V. S.

AUG 28 1937

RECEIVED

CERTIFICATE OF DEATH

08292

Reg. Dist. No.

08297

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rosedale				c. LENGTH OF STAY IN 1b 1 year			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8312 Philadelphia Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Henry Hucknall				4. DATE OF DEATH Month Day Year 8 11 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/8/1870	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher of golf				10b. KIND OF BUSINESS OR INDUSTRY Professional golf		11. BIRTHPLACE (State or foreign country) Markfield	
13. FATHER'S NAME Henry Hucknall				14. MOTHER'S MAIDEN NAME Elizabeth Markfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. 049-21-2079		17. INFORMANT Mrs. Sarah Hucknall	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 31X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4:00 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8019 Philadelphia Road #6, Md.							
ACTUAL SIGNATURE Ermest P. Davis				M.D. 8019 Philadelphia Road #6, Md.			
PHYSICIAN'S NAME (Type) Ermest P. Davis M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/13/57		22c. NAME OF CEMETERY OR CREMATORY Greenmount		22d. LOCATION (City, town, or county) (State) Balto. Co. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas Funeral Home				ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR Edith Harley	
				24b. REGISTRAR'S SIGNATURE			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08293/4
Reg. Dist. No.

08298

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Co. Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3501-4			
f. STREET ADDRESS 530 Brune St.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Andrew Middle Jackson Last Jackson				4. DATE OF DEATH Month 8 Day 20 Year 1957			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months 8 Days 20	IF UNDER 24 HRS. Hours 19 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mouldman		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tom Jackson				14. MOTHER'S MAIDEN NAME Annie Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ada Jackson; Wife		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour 9 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M. B. Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M. B. Davis, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 25, 1957		22c. NAME OF CEMETERY OR CREMATORY Jerusalem Cemetery		22d. LOCATION (City, town, or county) (State) Gastonia, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest Wilson				24a. REC'D BY REGISTRAR 22 1957		24b. REGISTRAR'S SIGNATURE Lawson L. Farley	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. B.

AUG 22 1957

RECEIVED

08299

CERTIFICATE OF DEATH

08294 *38*

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armcast Nursing Hom -812 Register Ave.				d. STREET ADDRESS 613 Murdock Rd.			
3. NAME OF DECEASED (Type or print) First ANNA Middle H. Last JOHANSON				4. DATE OF DEATH Month August Day 25 Year 19 57			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1888	9. AGE (In years last birthday) yrs. 68	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Herman Wessel				14. MOTHER'S MAIDEN NAME Katherine Gehrels			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Albert E. Johanson - 613 Murdock Rd.			
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke DUE TO Generalized Arteriosclerosis - V. Cerebral Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6201 York Rd		
					20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 1, 1957 to Aug 25, 1957 , that I last saw the deceased alive on August 19, 1957 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles E. Carr, Jr., M.D.				ADDRESS (Street, city or town, state) 6201 York Rd #12			
PHYSICIAN'S NAME (Type)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/28/57		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Baltor.				24. REC'D BY REGISTRAR Aug 30 1957			
				24b. REGISTRAR'S SIGNATURE Mabel Guyer			

BUREAU V. S.

AUG 30 1957

RECEIVED

RECEIVED
AUG 29 1957
BUREAU V. S.

08301

CERTIFICATE OF DEATH

08296

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Rosedale</u>			
c. LENGTH OF STAY IN TB <u>40 years</u>				d. STREET ADDRESS <u>6713 Kenwood Avenue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6713 Kenwood Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Caroline</u> Middle <u>M.</u> Last <u>Kern</u>				4. DATE OF DEATH Month <u>8</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/1/1896</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>Frederick h. Wienecke</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. Joseph F. Kern 6713 Kenwood Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Portal obstruction due to Metastases</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>57</u> , to <u>Aug 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 11</u> , 19 <u>57</u> , and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Baumgardner M.D.</u>				ADDRESS (Street, city or town, state) <u>Balto Md</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED <u>8/12/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>August 14/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Zion Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold H. Funeral Home</u>				ADDRESS <u>7401 Belair Rd.</u>		24a. REC'D BY REGISTRAR <u>Edith Hurler</u>	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

416

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar after to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

08302

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08297

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 117 WINTERS AVE.		d. STREET ADDRESS 117 WINTERS AVE. (117)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mamie First King Middle King Last		4. DATE OF DEATH Month August Day 2 Year 19 57	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home domestic		10b. KIND OF BUSINESS OR INDUSTRY Home Duties	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U .S. A.	
13. FATHER'S NAME Perry Dorsey		14. MOTHER'S MAIDEN NAME Sidney Bennett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Mary Adams		Address 42, Bloomingdale R.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac failure 11111 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiovascular disease (c) DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE GEO. S. M. KIEFFER		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) GEO. S. M. KIEFFER		M. D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-5-57	
22c. NAME OF CEMETERY OR CREMATORY Lushey Park Cem.		22d. LOCATION (City, town, or county) (State) Cooksville, Howard Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Frances A. Hensley		ADDRESS 578 W Riddle St	
24a. REC'D BY REGISTRAR Aug 6, 57		24b. REGISTRAR'S SIGNATURE ...	

BUREAU Y. R.

AUG 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08298

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Howlesburg</u>		c. LENGTH OF STAY IN 1b <u>8 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Howlesburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>IDA - BROWN - KOLTACK</u>				4. DATE OF DEATH Month Day Year <u>Aug 20 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 13 - 1888</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Geo M. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Gill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-18-9730</u>		17. INFORMANT Address <u>Frank Koltack, Upper Marlboro Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> <u>464X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>T hrombophlebitis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>3 wks.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Hour a. m. p. m. <u>none 19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) <u>none</u>	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>D. D. Caples</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-20-57</u>	
EXAMINER'S NAME (Type) <u>D. D. Caples, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls</u>		22d. LOCATION (City, town, or county) <u>Camell Co Md</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw J Tipton</u>				ADDRESS <u>Hanover Md</u>		24a. REC'D BY REGISTRAR DATE <u>8-20-57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary B. Shive</u>

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2

U.S. AIR FORCE

1957

RECEIVED

08304

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

COUNTY **BALTIMORE** MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town)
 TOWN **COCKEYSVILLE** LENGTH OF STAY (in this place) **14 MONTHS**
 HOSPITAL OR INSTITUTION OR STREET ADDRESS **MASONIC HOME**

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE **MARYLAND** COUNTY
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR
 TOWN **BALTIMORE**
 STREET ADDRESS (If rural give location) **4311 BELVEIR AVE**

3. NAME OF DECEASED (Type or Print)

(First) **HENRY** (Middle) **HERMAN** (Last) **KRUSE**

4. DATE OF DEATH

(Month) **8** (Day) **12** (Year) **1957**

5. SEX

M

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (S)

MARRIED

8. DATE OF BIRTH

6-10-1882

9. AGE last birthday

75 yrs.

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

BOOK KEEPER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME

JOHN KRUSE

14. MOTHER'S MAIDEN NAME

MARGARET U'HONE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

212-03-0095 A

17. INFORMANT & ADDRESS

Frank E. Smith Jr., Cockeysville

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

18. MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

4. IMMEDIATE CAUSE (A) **Arterio-sclerotic Cardiac**
 ANTECEDENT CAUSE(S) DUE TO
 DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) **Vascular disease**
 DUE TO (C)

6 month

11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **6-1**, 19 **56**, to **8-7**, 19 **57**, that I last saw the deceased alive on **8-7**, 19 **57**, and that death occurred at **4:05 A.M.** from the causes and on the date stated above.

SIGNATURE

Walter T. Lees

M.D.

ADDRESS (Street, city, town, state)

Cockeysville, Md.

DATE SIGNED

8-12-57

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

Aug. 14, 1957

NAME OF CEMETERY OR CREMATORY

London Park Cemetery

LOCATION (City, town, or county)

Baltimore, Maryland

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

W. Lees

25. FUNERAL DIRECTOR'S SIGNATURE

William Cook, Inc. 1217 St. Paul Street

DATE

AUG 13 '57

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

AUG 13 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

08305

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08309

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockdale, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Milford Swimming Pool				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elmer Middle E. Last Leshor Jr.				4. DATE OF DEATH Month August Day 27 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 11, 1939	
9. AGE (In years last birthday) 18 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Display Dept.		11. BIRTHPLACE (State or foreign country) Clear Spring, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer E. Leshor Sr.				14. MOTHER'S MAIDEN NAME Maudie E. Hull			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) *****		16. SOCIAL SECURITY NO. *****		17. INFORMANT Mr. Elmer E. Leshor Sr. 3605 Kenmar Road.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO 929.3							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 4 hrs.							
DUE TO (c) none							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH none				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased drowned while swimming.			
20c. TIME OF INJURY Month, Day, Year 8-28-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) swimming pool		20f. (City or town) Rockdale, Balto. (County) Balto. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE D. D. Caples				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) D. D. Caples, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 30/57		22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		22d. LOCATION (City, town, or county) Clear Spring, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers				24a. REC'D BY REGISTRAR Dr. Jm. Martin		24b. REGISTRAR'S SIGNATURE Dr. Jm. Martin	

MEDICAL CERTIFICATION

BUREAU V. S.

SEP 9 1957

RECEIVED

08306

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08301

CERTIFICATE OF DEATH

Reg. Dist. No.

2. DATE OF DEATH
Aug 6, 19571. NAME OF DECEASED
(Type or Print)

Evelyn Levi

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF (If in hospital or institution, give street address or location)
Belle Farm, Old Court Rd
Pikesville, Maryland

C. Length of stay in Baltimore

Life

Yrs.
Mos.
Days

5. SEX

Female

6. COLOR OR RACE

White

7. SINGLE, MARRIED,

WIDOWED, DIVORCED (Specify)

Widow

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housework

10B. KIND OF BUSINESS OR INDUSTRY

13. FATHER'S NAME

George Seldner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Georgie Feldman, Cambridge, Md

18. 1957

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A)

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B)

DUE TO

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

(C)

INTERVAL BETWEEN ONSET AND DEATH

4 1/2 hr.

1 hr.

15 days

15 days

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒

21A. TIME (Month) (Day) (Year) (Hour) OF INJURY

21B. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

21C. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19... to 19... that (I) (we) last saw the deceased alive on 19... and that death occurred at m. from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

DATE RECEIVED BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Burial

8-9-57

Baltimore Hebrew Cem

Baltimore, Maryland

1957

David R. Martin

David R. Martin, 1902

Putaw Place

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

RECEIVED
U. S.

08307

CERTIFICATE OF DEATH

08302/4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Maryland c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Baltimore d. STREET ADDRESS 1015 Renick Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle A. Last LEWIS		4. DATE OF DEATH Month August Day 12 Year 1957					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH September 9, 1885	9. AGE (In years last birthday) yrs. 71	IF UNDER 1 YEAR: Months 71 Days 71 Hours 71 Min 71		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Poultry House		11. BIRTHPLACE (State or foreign country) Baltimore, Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph F. Lewis		14. MOTHER'S MAIDEN NAME Mary Foosa			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO.		17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF RECTAL SIGMOID COLON WITH METASTASIS TO LIVER DUE TO 154x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) 154x DUE TO (c) 154x INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19 a. m. 19 p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from August 6, 1957 to August 12, 1957 and that death occurred at 5:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Md. DATE SIGNED 8/12/57							
ACTUAL SIGNATURE Chien Wei Lan		M.D. Chien Wei Lan					
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M. D.		VAH, Fort Howard, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/16/57	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons, North & Pa. Avenues		ADDRESS Baltimore, Md.		24a. REC'D BY REGISTRAR DATE 8/13/57	24b. REGISTRAR'S SIGNATURE Darwin L. Fisher		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 14 1937

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caves Road		d. STREET ADDRESS Caves Road	
3. NAME OF DECEASED (Type or print) First DRUMMOND Middle WILLIAMSON Last LITTLE		4. DATE OF DEATH Month Aug. Day 20 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1895
9. AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		11. BIRTHPLACE (State or foreign country) Hartford Steam Boiler Inspection & Ins. Co. Penna.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Thomas Little	
14. MOTHER'S MAIDEN NAME Charlotte Wolcott Dennis		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes World War I	
16. SOCIAL SECURITY NO. 215-07-1905		17. INFORMANT Mrs. Jane Little - Garrison P. O., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 8 mo
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 4, 1955 to Aug 19, 1955 ; that I last saw the deceased alive on Aug 19, 1955 , and that death occurred at 10:45 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Waverly S. Green, Jr. M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Pikesville 8, Md.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 8/22/57	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	22d. LOCATION (City, town, or county) (State) Hartford, Conn.
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tiekner & Sons		ADDRESS P.O. 17, Md.	24a. REC'D BY REGISTRAR DATE 8/27/57
		24b. REGISTRAR'S SIGNATURE Mary Eline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LIBRARY

JUN 23 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08309

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 File 2-9-57-1-57 at

CERTIFICATE OF DEATH

08304

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebbville				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7501 Windsor Mill Road				d. STREET ADDRESS 7501 Windsor Mill Road.			
3. NAME OF DECEASED (Type or print) First Margaret Middle C. Last Lowrey				4. DATE OF DEATH Month August , 18th 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 31st. 1895	9. AGE (In years last birthday) yrs. 61	IF UNDER 1 YEAR Months Days Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Balto. Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Haymire				14. MOTHER'S MAIDEN NAME Kate Emire			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-20-9434		17. INFORMANT Mrs George Lehr, 7501 Windsor Mill Rd. Baltimore 7 Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Congestive Heart Failure Acute & chronic. DUE TO (b) Myocarditis chronic DUE TO (c) Pneumonia Bases Bilat. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Phlebotis Superficial Varicosities Leg Rt.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from July 1957 to 18 Aug 1957 that I last saw the deceased alive on 17 Aug 1957 and that death occurred at 3.30 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE W.E. McGrath				ADDRESS (Street, city or town, state) 1709 Edmondson Ave, Catonsville, Md			
PHYSICIAN'S NAME (Type) W.E. McGrath				DATE SIGNED 1303 Frederick Rd			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 21 1957		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown, Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Emilia Luimoreau				ADDRESS 4510 Liberty Heights Avenue		24a. REC'D BY REGISTRAR Aug 21 1957	
				24b. REGISTRAR'S SIGNATURE John Martin			

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U. S. DEPT. OF JUSTICE

RECEIVED
U. S. DEPT. OF JUSTICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08310

CERTIFICATE OF DEATH

08305

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lochearn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lochearn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3728 Sylvan Avenue</u>		d. STREET ADDRESS <u>3728 Sylvan Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Walter J. Mac Dermott</u>		4. DATE OF DEATH Month Day Year <u>August 10th 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 25, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Barr Teller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Thomas J. Mac Dermott</u>		14. MOTHER'S MAIDEN NAME <u>Anna Price</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>417-03-7930</u>	
17. INFORMANT <u>A Mrs. Edith M. Mac Dermott, same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Parkinson's Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1950</u> to <u>August 1957</u> , that I last saw the deceased alive on <u>August 12, 1957</u> , and that death occurred at <u>3:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis Dalman</u>		ADDRESS (Street, city or town, state) <u>Pikesville, Md.</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS DALMAN</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8, 13/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road.</u>	
24a. REC'D BY REGISTRAR <u>AL</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. J. H. Martin</u>	

BUREAU V. E.

JUG 13 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08311

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> COUNTY <i>1</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>College Manor</i>		d. STREET ADDRESS <i>1721 Kurtz ave</i>	
3. NAME OF DECEASED (Type or print) First <i>FRANK</i> Middle <i>MACEY</i> Last <i>MACEY</i>		4. DATE OF DEATH Month <i>Aug</i> Day <i>23</i> Year <i>1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr 27 1874</i>
9. AGE (in years last birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Contractor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Bus.</i>	
11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Macey</i>		14. MOTHER'S MARDEN NAME <i>Elizabeth Davis</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>	
17. INFORMANT <i>College Manor, Lutherville Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> DUE TO <i>Cerebral Arterio-Sclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Arterio-Sclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>50</i> , to <i>Aug 23</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Aug 22</i> , 19 <i>57</i> , and that death occurred at <i>2:08 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Crawford N. Kirkpatrick Jr</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>6 E. Eager St, Baltimore Aug 23, 1957</i>	
PHYSICIAN'S NAME (Type) <i>DR. CRAWFORD N. KIRKPATRICK, JR.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>Aug 26, 1957</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Giovans Presbyterian Ch.</i>	22d. LOCATION (City, town, or county) (State) <i>Bellona ave Balt. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry N. Kerbinson & Sons Co.</i>		ADDRESS <i>4905 York Rd</i>	
24a. REC'D BY REGISTRAR DATE <i>AUG 23 '57</i>		24b. REGISTRAR'S SIGNATURE <i>W. Search</i>	

BUREAU V. S.

AUG 28 1967

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1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08312

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08307

CERTIFICATE OF DEATH

Reg. Dist. No. 17

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>296 Hillcrest Road</u>		d. STREET ADDRESS <u>3005 Shannon Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marie D. Manner</u>		4. DATE OF DEATH Month Day Year <u>Aug 19 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan-18-1899</u>
9. AGE (In years lost birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>St. Clare</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <u>William Toland</u>		14. MOTHER'S MAIDEN NAME <u>Mary Batzer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>596 Hillcrest Rd - 24</u>	
17. INFORMANT <u>John Manner</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>437.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1957</u> to <u>Date</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 17</u> , 19 <u>57</u> , and that death occurred at <u>3:40 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert J. Lyden</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>815 Eastern Ave. Balto Md.</u> <u>Aug 19, 1957</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8/22/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore - Balto Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Mullen Inc - 2431 E. Olney St</u>		24a. REC'D BY REGISTRAR <u>DATE 8-23-57</u>	24b. REGISTRAR'S SIGNATURE <u>Edith Hurlbutt</u>

RECEIVED
AUG 10
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08313

CERTIFICATE OF DEATH

08308

Reg. Dist. No. 44

1 PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Howard				c LENGTH OF STAY IN lb 22 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
3 NAME OF DECEASED (Type or print) JOHN T. MARBURG				4. DATE OF DEATH August 15 19 57			
5. SEX Male		6. COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH September 29, 1889	
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sail Maker		10b. KIND OF BUSINESS OR INDUSTRY Canvas Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Peter Marburg				14 MOTHER'S MAIDEN NAME Jennie Imhoff			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes WW I				16 SOCIAL SECURITY NO 214-03-3814		17. INFORMANT Clin. Rec. Vets. Admin. H	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE DUE TO BLEEDING DUODENAL ULCER WITH OBSTRUCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUODENAL ULCER (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ventricular hypertrophy and strain and/or anterio lateral myocardial						INTERVAL BETWEEN ONSET AND DEATH 3 months 3 months 22 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) damage			
20c. TIME OF INJURY Month, Day, Year 19 57		20d INJURY OCCURRED VA While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 21 19 57 , to August 15 19 57 , and that death occurred at 10:55 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH Ft. Howard, Md DATE SIGNED 8/16/57							
ACTUAL SIGNATURE Joseph M. Miller M.D. VAH Ft. Howard, Md				PHYSICIAN'S NAME (Type) JOSEPH M. MILLER, M.D., Chief, Surgical Service			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Witke Funeral Director ADDRESS 4101 Edmondson Ave. Balto. Md				24a. REC'D BY REGISTRAR 8/20/57		24b. REGISTRAR'S SIGNATURE Lawson L. Fisher	

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AUG 29 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

08314

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08309

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COCKEYSVILLE				c. LENGTH OF STAY IN 1b 20 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MASONIC HOME				d. STREET ADDRESS 920 NORTH MONROE ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HELEN Middle ELIZABETH Last MASK				4. DATE OF DEATH Month AUG Day 22 Year 1957			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-7-1875	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME WILLIAM A. MASK				14. MOTHER'S MAIDEN NAME MARTHA E. KENNY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) NO				16. SOCIAL SECURITY NO. -			
17. INFORMANT Frank R. Smith Jr.				Address Cockeysville, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Vascular Heart DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac disease DUE TO (c)							3 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 6-26 , 1950, to 8-21 , 1957, that I last saw the deceased alive on 8-21 , 1957, and that death occurred at 7 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Helen I. Coe				ADDRESS (Street, city or town, state) Cockeysville, Md			
DATE SIGNED 8/22/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL							
22b. DATE THEREOF 8-26-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Olive		22d. LOCATION (City, town, or county) (State) BALTO. Md			
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook				ADDRESS 1217 St Paul St		24a. REC'D BY REGISTRAR AUG 26 '57	
24b. REGISTRAR'S SIGNATURE Paul St							

BUREAU V. S.

JUG 1957

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08315

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 0831044

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN lb 291 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. STREET ADDRESS 2513 E. Chase Street			
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM A. MC CART				4. DATE OF DEATH Month Day Year August 15 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/15/04		9. AGE (in years last birthday) 53 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Unemployed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph McCart				14. MOTHER'S MAIDEN NAME Barbara Reichert			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) Yes WWII		16. SOCIAL SECURITY NO. 217-16-1845		17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Fort Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LARYNX (SURGICALLY REMOVED) WITH METASTASES TO RIGHT PLEURA, RIGHT LUNG, KIDNEYS AND REGIONAL SUBCUTANEOUS TISSUE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 28, 19 56, to August 15, 19 57 , and that death occurred at 6:23 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Chien Wei Lan				ADDRESS (Street, city or town, state) Veterans Administration Hospital			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.				DATE SIGNED 8/16/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/19/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				ADDRESS 5305 Harford		24a. REC'D BY REGISTRAR Aug 19 1957	
				24b. REGISTRAR'S SIGNATURE Lawson L. Lark			

LEONARD J. RUCK FUNERAL HOME, 5305 Harford Rd, Balto., Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

AUG 19 1957

RECEIVED

08316

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

083118

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. LENGTH OF STAY IN 1b 2 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Presbyterian Home				d. STREET ADDRESS 4008 Penhurst Ave.			
3. NAME OF DECEASED (Type or print) First Hannah Middle May Last McConkey				4. DATE OF DEATH Month Aug. Day 5 Year 1957			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1878		9. AGE (In years last birthday) 78 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Carroll Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Josiah Unger				14. MOTHER'S MAIDEN NAME Rebecca Reese			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records of Presbyterian Home Address Towson, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-renal-vascular disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Senile changes DUE TO (c) Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH Unknown Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 12 , 1955, to Aug 5 , 1957, that I last saw the deceased alive on Aug 1 , 1957, and that death occurred at 4 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Rollin C. Hudson M.D.				ADDRESS (Street, city or town, state) 606 Baltimore Ave Towson Md			
PHYSICIAN'S NAME (Type) Rollin C. Hudson MD				DATE SIGNED 8/5/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 7, 1957		22c. NAME OF CEMETERY OR CREMATORY Krieders		22d. LOCATION (City, town, or county) (State) Westminster, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons Inc.				ADDRESS 1900 Eutaw Place		24a. REC'D BY REGISTRAR DATE 10 7 1957	
				24b. REGISTRAR'S SIGNATURE Mark Gayn			

BUREAU A. S.

AUG 7 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08229

CERTIFICATE OF DEATH

08312

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>539 Main St</u>		e. STREET ADDRESS <u>539 Main St</u>	
3. NAME OF DECEASED (Type or print) First <u>Beatrice</u> Middle <u>McDonald</u> Last <u>McDonald</u>		4. DATE OF DEATH Month <u>8</u> Day <u>15</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-13-13</u>
9. AGE (in years last birthday) <u>44</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (State or foreign country) <u>King & Queen Co. Va</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Cecil Lockley</u>		14. MOTHER'S MAIDEN NAME <u>Vernie Brookenburg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Helton</u>		Address <u>539 Main St - Dundalk</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uterine Carcinoma</u> <u>174X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.	20d. INJURY OCCURRED <u>While at work</u> <input checked="" type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>July 1, 1957</u> to <u>August 15, 1957</u> , that I last saw the deceased alive on <u>August 15, 1957</u> , and that death occurred at <u>8:50 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Thomas</u> M.D.		ADDRESS (Street, city or town, state) <u>107 N. Main St Balto</u>	
DATE SIGNED <u>22 May</u>			
PHYSICIAN'S NAME (Type) <u>J. H. Thomas</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>8-18-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>2nd Mt. Olive</u>	22d. LOCATION (City, town, or county) (State) <u>Little Phymouth Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel W. Sullivan Jr.</u> ADDRESS <u>Balto.</u>		24a. REG'D BY REGISTRAR <u>JUG 19 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Mr. Kelly</u>	

TREAU V. S.

AUG 19 1957

RECEIVED

08317

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevenson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Villa Julie		d. STREET ADDRESS Valley Rd.	
3. NAME OF DECEASED (Type or print) First Middle Last Sister Mary Gabrielle McEnroe		4. DATE OF DEATH Month Day Year Aug. 27, 1957 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1876
9. AGE (In years lost birthday) yrs. 80		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Religious	
11. BIRTHPLACE (State or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas McEnroe		14. MOTHER'S MAIDEN NAME Hannah Sherlock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT Villa Julie Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Oesophagus. 150 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Nov 1956	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1956 to Aug 27, 1957 , that I last saw the deceased alive on Aug 24, 1957 , and that death occurred at 10:00 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Harold H Burns M.D.			
PHYSICIAN'S NAME (Type) Harold N. Burns 115 E. AGER Ave. 2. md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-29-57	22c. NAME OF CEMETERY OR CREMATORY Trinity Convent Cem.	22d. LOCATION (City, town, or county) (State) Ilchester Md.
23. FUNERAL DIRECTOR'S SIGNATURE Swales Funeral Home, Catonsville Md		24a. REC'D BY REGISTRAR Aug 30 1957	
ADDRESS		24b. REGISTRAR'S SIGNATURE Mabel Gray	

RECEIVED

AUG 30 1957

BUREAU V. S.

CERTIFICATE OF DEATH

083148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6205 Falls Rd.</u>				d. STREET ADDRESS <u>6205 Falls Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>C. Herbert McMahon</u>				4. DATE OF DEATH Month Day Year <u>8 28 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-27-1909</u>	9. AGE (In years last birthday) <u>48</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto City P.S.</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>C. McMahon</u>				14. MOTHER'S MAIDEN NAME <u>Nona P. Bond</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Family</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CANCER OF LUNG</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>8 MOS.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>8-23-1957</u> to <u>8-28-1957</u> , that I last saw the deceased alive on <u>8-28-1957</u> , and that death occurred at <u>9P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benji B. Moses, M.D.</u>				ADDRESS (Street, city or town, state) <u>448 N. Luzerne Ave. Balto. Md.</u>			
DATE SIGNED <u>8-30-57</u>							
PHYSICIAN'S NAME (Type) <u>BENJ. B. MOSES, M.D.</u>				<u>Balto. Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-31-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Saturne Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mc Culley Funeral Home</u>				ADDRESS <u>130 E. Fort Ave.</u>		24a. REC'D BY REGISTRAR <u>DATE D 3 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Markel Gay</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

SEP 3 1937

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

08319

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08315

Item 2

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE - HOME OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Penn.</u>	CITY/TOWN <u>Columbia, Pa.</u>
CITY <u>Campbell</u>	LENGTH OF STAY <u>1 year</u>	CITY/TOWN <u>Columbia, Pa.</u>	OR TOWN <u>Columbia, Pa.</u>
TOWN <u>Campbell</u>		STREET ADDRESS <u>537 Locust Street</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Augsburg Home</u>			
3. NAME OF DECEASED: (First) <u>LOUISE</u> (Middle) <u>MEHL</u> (Last) <u>MEHL</u>		4. DATE (Month) (Day) (Year) <u>8 27 1957</u>	
SEX <u>female</u>		5. AGE (last birthday) <u>88</u>	
6. RACE <u>white</u>		7. DATE OF BIRTH <u>June 21, 1869</u>	
8. MARRIAGE STATUS <u>single</u>		9. AGE (last birthday) <u>88</u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Columbia Penn</u>	
13. FATHER'S NAME: <u>John Christian Mehl</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
14. MOTHER'S MAIDEN NAME: <u>Maie K. Hoin</u>		15. SOCIAL SECURITY NO. <u>none</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		17. INFORMANT & ADDRESS: <u>Augsburg Home, Fulton P. Tyler</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>174X</u>		<u>8 mo.</u>	
ANTECEDENT CAUSE (S):		<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE, LAST:			
(A) <u>- - Carcinoma of Uterus</u>			
(B) <u>Arterio - Sclerotic Heart Disease -</u>			
(C) <u>none</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<u>none</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>8/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/20</u> , 19 <u>57</u> , and that death occurred at <u>M. from the causes and on the date stated above.</u>			
SIGNATURE <u>Paul L. Chambers</u>		DATE SIGNED <u>8-27-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Columbus Pn.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8/27</u>		REGISTRAR'S SIGNATURE <u>Paul A. Lyons</u>	
24. FUNERAL DIRECTOR <u>Paul A. Lyons</u>		ADDRESS <u>Columbia, Pa.</u>	

RECEIVED
AUG 29 1957
BUREAU A. A.

1
FOR STATE
HEALTH DEPT.

08320

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08316

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
c. LENGTH OF STAY IN 1b 18 yrs		d. STREET ADDRESS 8704 Raven Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8704 Raven Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARLAND Middle R. Last MORGAN		4. DATE OF DEATH Month August Day 29 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/15/14
9. AGE (in years last birthday) 43 yrs		10. IF UNDER 1 YEAR Months 43 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beckley Radio		11. BIRTHPLACE (State or foreign country) West. VA.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME C. C. MORGAN	
14. MOTHER'S MAIDEN NAME LAURA B. MORGAN		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. Records		17. INFORMANT Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty Liver 581.1 Conditions, if any, which gave rise to immediate cause (b) Chronic Alcoholism. (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. S. Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/30/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Sept 1, 1957	
22c. NAME OF CEMETERY OR CREMATORY Monte Vista		22d. LOCATION (City, town, or county) (State) Princeton, W. VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. F. Fisher & Son		24a. REC'D BY REGISTRAR SEP 3 1957	
ADDRESS 112 N. Mt. Royal		24b. REGISTRAR'S SIGNATURE Michael Guyon	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1957

RECEIVED

1. 8. 1.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(S)
5M 9/55

08230

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08317

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. LENGTH OF STAY IN 1b <u>DUNDALK 53</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1963 DENBURY ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>P.</u> Last <u>MORISI</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 22 1906</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILL FOREMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL CO</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>EMIL MORISI</u>				14. MOTHER'S MAIDEN NAME <u>LOUISE BRUNETTE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>216-01-2008</u>		17. INFORMANT Address <u>MRS CATHERINE MORISI 1963 DENBURY</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>—</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M B Davis</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M B. DAVIS MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 27 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULLRICH FUNERAL HOME DUNDALK MD</u>				24a. REC'D BY REGISTRAR <u>DATE AUG 28 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Ann Kelly</u>	

MEDICAL CERTIFICATION

RECEIVED

AUG 27 1957

BUREAU V. 3

08321

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08318 38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kiderwood</u>	c. LENGTH OF STAY IN 1b <u>54 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kiderwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>7922 Glenham Road</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>JOSEPH P. MYER</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 9-1862</u>
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Logan Ohio</u>	11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>
13. FATHER'S NAME <u>August Myer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Phillips</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Robert F. Myer</u>		Address <u>7922 Glenham Rd</u>	
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>120.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, General</u> DUE TO (c) <u>Unk</u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 M</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Aug 6, 1957</u> to <u>Aug 6, 1957</u> , that I last saw the deceased alive on <u>Aug 6, 1957</u> , and that death occurred on <u>Aug 6, 1957</u> at <u>5:55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bennett A. Stacey</u>		ADDRESS (Street, city or town, state) <u>Riverhill</u>	
PHYSICIAN'S NAME (Type) <u>BENNETT A. STACEY</u>		DATE SIGNED <u>8/7/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 9-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns Son</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 9 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Mabel Gray</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 9 1957

BUREAU V. S.

08231

CERTIFICATE OF DEATH

08319

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>OHIO</u> b. COUNTY <u>JEFFERSON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TORONTO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6132 WOODLEY RD</u>				d. STREET ADDRESS <u>210 N. THIRD AVE</u>			
3. NAME OF DECEASED (Type or print) First <u>AMELIA</u> Middle <u>URBAN</u> Last <u>O'BRIEN</u>				4. DATE OF DEATH Month <u>8</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>16 SEPT</u>	9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>MICHAEL O'BRIEN</u>				14. MOTHER'S MAIDEN NAME <u>MARY KELLY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>MRS. FRANK WRIGHT</u>				Address <u>6732 WOODLEY RD DUNDALK</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CA of Colon</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. g. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7-25</u> , 195 <u>7</u> , to <u>8-16</u> , 195 <u>7</u> , that I last saw the deceased alive on <u>8-16</u> , 195 <u>7</u> , and that death occurred at <u>11:15</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2 Kingship Baltimore 22 Md</u> DATE SIGNED <u>8-17-57</u>							
ACTUAL SIGNATURE <u>Jack Collins</u>				M.D. <u>2 Kingship</u>			
PHYSICIAN'S NAME (Type) <u>JACK COLLINS</u>				<u>Baltimore 22 Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/27/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>UNION</u>		22d. LOCATION (City, town, or county) (State) <u>TORONTO, OHIO</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Kelly</u>				ADDRESS <u>Dundalk, Md</u>		24a. REC'D BY REGISTRAR <u>Wm. J. Kelly</u>	
				DATE <u>AUG 18 1957</u>			

RECEIVED
AUG 19 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08322

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08320

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RODGERS FORGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X- RODGERS FORGE</u>			
c. LENGTH OF STAY IN 1b <u>4 yrs</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>144 MURDOCK RD</u>				d. STREET ADDRESS <u>144 MURDOCK RD</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELIZABETH</u> Last <u>O'BRIEN</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 21, 1913</u>	9. AGE (In years last birthday) <u>42</u> yrs	10. IF UNDER 1 YEAR Months <u>1</u> Days <u>10</u> Hours <u>19</u> Min. <u>57</u>	11. IF UNDER 24 HRS Months <u>1</u> Days <u>10</u> Hours <u>19</u> Min. <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HE HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William J Larkin</u>				14. MOTHER'S MAIDEN NAME <u>Nester Ingram</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-65-1727</u>		17. INFORMANT <u>Wsp CHART BEN SECOURS</u> Address <u>2025 W Fayette St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Papillary cystadenoma carcinom. L ovary</u> 11 X <u>11</u> <u>91</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>11</u> (b) <u>Uterine leiomyosarcoma</u> <u>11</u> <u>91</u> (c) <u>Uterine leiomyosarcoma</u> <u>11</u> <u>91</u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 mo</u> <u>5 mo</u> <u>3 mo</u> <u>2 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uterine leiomyosarcoma</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan 13</u> , 19 <u>56</u> , to <u>Aug 10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 4</u> , 19 <u>57</u> , and that death occurred at <u>10:54 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>S. D. Sullivan</u>				M.D. <u>1129 St Paul St</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>Aug 18, 1957</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 13, 1957</u>		<u>New Catholic Cem</u>		<u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Sullivan</u> ADDRESS <u>118 W. Mt. Royal Ave</u>				24a. REC'D BY REGISTRAR <u>AUG 14 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Malcolm Gray</u>	

BUREAU V. S.

1917

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08323

CERTIFICATE OF DEATH

08321

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CEDAR BEACH</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO CEDAR BEACH</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOX 115 POPLAR RD.</u>				d. STREET ADDRESS <u>Box 115 POPLAR RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES LUKE O'CONNOR</u>				4. DATE OF DEATH Month Day Year <u>AUG 8 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 6 - 1886</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BARBER</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. M.D.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>O'CONNER</u>				14. MOTHER'S MAIDEN NAME <u>CARLINE O MIESE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>DORA O'CONNOR</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary carcinoma</u> DUE TO (c) <u>metastatic</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1955</u> to <u>8/8 1957</u> , that I last saw the deceased alive on <u>8/7 1957</u> , and that death occurred at <u>8:00</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. PLATT</u>				ADDRESS (Street, city or town, state) <u>424 Eastern Ave. M.D.</u>			
PHYSICIAN'S NAME (Type) <u>J. PLATT</u>				DATE SIGNED <u>EARLY MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>				ADDRESS <u>418 Eastern Ave</u>		24a. REC'D BY REGISTRAR <u>AUG 13 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Edith Hawley</u>			

BUREAU N. E.

111

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08324

CERTIFICATE OF DEATH

08322

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 5932 Marluth Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GUST Middle - Last OYOSOSKI				4. DATE OF DEATH Month August Day 6 Year 19 57			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 11, 1887	
				9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY City government		11. BIRTHPLACE (State or foreign country) Poland	
13. FATHER'S NAME Frank Oyososki				14. MOTHER'S MAIDEN NAME Minnie MN: Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes (If yes, give year or dates of service) WW I				16. SOCIAL SECURITY NO. 215-22-3034		17. INFORMANT Address Glin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OLD CEREBRAL INFARCTION DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 2 YEARS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that VA attended the deceased from July 30, 1957 , to August 6, 1957 and that death occurred at 5:40 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VAH, FORT HOWARD, MARYLAND 8/8/57							
ACTUAL SIGNATURE Chien Wei Lan				M.D. VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/15/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE James L. McCully				24a. REC'D BY REGISTRAR AUG 2 1957		24b. REGISTRAR'S SIGNATURE James L. McCully	

RECEIVED
AUG 19 1957
BUREAU V. S.

08325

CERTIFICATE OF DEATH

08323 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 84 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 1216 N. BRADFORD STREET	
3. NAME OF DECEASED (Type or print) First Middle Last FRANCIS A. PODZIMEK		4. DATE OF DEATH Month Day Year AUGUST 16, 19 57	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 19, 1924
9. AGE (In years last birthday) yrs. 33		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min	
10a. USAL OCCUPATION (Give kind of work done during most of working life, even if retired) INVENTORY CLERK		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WENCESLAUS PODZIMEK		14. MOTHER'S MAIDEN NAME HELEN HRADSKY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES 9-30-50/1-31-52		16. SOCIAL SECURITY NO 216-14-4559	
17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) MESENTERIC THROMBOSIS 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ILEITIS; INTESTINAL POLYPOSIS; DURATION UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 24, 19 57 , to August 16, 19 57 and that death occurred at 5:05 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 8-16-57			
ACTUAL SIGNATURE T. Lawrence Fleisher M.D.		PHYSICIAN'S NAME (Type) T. Lawrence Fleisher M.D. VAH, Fort Howard, Maryland 8-16-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-20-57	22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Philip E. Cvach, 2716-18 E. Monument St., Baltimore, Maryland		24a. REC'D BY REGISTRAR AUG 19 1957 24b. REGISTRAR'S SIGNATURE Deason L. Thayer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.

RECEIVED

AUG 19 1957

BUREAU V. S.

08326

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>736 Edmondson Avenue</i>		d. STREET ADDRESS <i>736 Edmondson Avenue</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mrs. Sadie L. Pohlhaus</i>		4. DATE OF DEATH <i>August 20 19 57</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 7, 1883</i>
9. AGE (In years last birthday) <i>74 yrs</i>		IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>
13. FATHER'S NAME <i>John Laggerty</i>		14. MOTHER'S MAIDEN NAME <i>Bridget</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mr. Bernard V. Pohlhaus,</i> Address <i>same</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Degenerative Cardiovascular Disease</i> <i>400.1</i> DUE TO <i>Coronary sclerosis and insufficiency</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Acute Myocardial failure</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>May 19 55</i> to <i>20 Aug. 19 57</i> , that I last saw the deceased alive on <i>20 Aug. 19 57</i> and that death occurred at <i>3:30 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Joseph E. Muse, Jr.</i>		ADDRESS (Street, city or town, state) <i>1725 North Charles Street</i> DATE SIGNED <i>8/20/57</i>	
PHYSICIAN'S NAME (Type) <i>Joseph E. Muse, Jr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8/23/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Hargord Road #14</i>		24a. REC'D BY REGISTRAR <i>MS 22 57</i>	24b. REGISTRAR'S SIGNATURE <i>Quinn</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

JUG 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Filed 8-14-57

CERTIFICATE OF DEATH

08325

Reg. Dist. No.

32

1 PLACE OF DEATH a COUNTY Baltimore County MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b STATE MARYLAND b COUNTY CITY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Md.		c. LENGTH OF STAY IN 1b BALTIMORE 3Y01-4	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d STREET ADDRESS 1323 W. FAYETTE ST.	
3 NAME OF DECEASED (Type or print) Meta Meta Daniels Daniels POTTER		4. DATE OF DEATH Aug. 10th 1957	
5. SEX F	6 COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-24-04
9. AGE (In years last birthday) 52 yn		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) WILMINGTON, DEL.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORSE W. DANIELS	
14 MOTHER'S MAIDEN NAME ANNA MAY CONROY		15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO 220-093633		17 INFORMANT Address Hospital Records, Mt. Wilson State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE 2X 1. FEAR ADVANCED PULMONARY TBC DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2. CARDIAC INSUFFICIENCY DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH about 6 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-8-57 , 1957, to 8-10 , 1957, that I last saw the deceased alive on 8-10- 1957, and that death occurred at 1:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE William Newcomer M.D.		Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) William Newcomer, M.D., Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-14-57	22c. NAME OF CEMETERY OR CREMATORY Silverbrook	22d. LOCATION (City, town, or county) (State) Wilmington, Del.
23 FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner		24a. REC'D BY REGISTRAR Wm. J. Lickner	24b. REGISTRAR'S SIGNATURE Dorothy Russell

RECEIVED

AUG 14 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08232

CERTIFICATE OF DEATH

08326/1

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>15 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2604 Gray Manor Terrace</u>				d. STREET ADDRESS <u>2604 GRAY MANOR TERR.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>TINNEY E. PUCKETT</u>				4. DATE OF DEATH Month Day Year <u>August 25 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-22-14</u>	9. AGE (In years last birthday) <u>43</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHOTING ROOM</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARTIN AIR.</u>		11. BIRTHPLACE (State or foreign country) <u>WILKES BARRE N.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WILLIAM BROOKS</u>				14. MOTHER'S MAIDEN NAME <u>MINNIE LANGFORD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Robt. H. PUCKETT</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACHEXIA</u> <u>199.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>UNDERNUTRITION</u> DUE TO (c) <u>Generalized Carcinomatosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <u>March 10, 1957</u> to <u>Aug 25, 1957</u> , that I last saw the deceased alive on <u>Aug 17, 1957</u> , and that death occurred at _____, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Orlando Benito</u> M.D.				ADDRESS (Street, city or town, state) <u>2903 W. WOODWELL RD.</u>			
PHYSICIAN'S NAME (Type) <u>OSCAR LEO BERRIOS MD.</u>				DATE SIGNED <u>8/25/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Aug 28. 57</u>		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>Northwest Baltimore M.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John C. Kelly</u>				ADDRESS <u>21431 E. Oliver St</u>		24a. REC'D BY REGISTRAR DATE <u>8/27/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Kelly</u>			

RECEIVED

AUG 24 1954

BUREAU V

08328

CERTIFICATE OF DEATH

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Fullerton</u>				c. LENGTH OF STAY IN TB <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8321 Belair Road</u>				d. STREET ADDRESS <u>8321 Belair Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Louisa</u> Middle <u>Agness</u> Last <u>Raab</u>				4. DATE OF DEATH Month <u>8</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/28/1862</u>	
9. AGE (In years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>Anton Paul</u>				14. MOTHER'S MAIDEN NAME <u>Agnes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Henry A. Raab</u> Address <u>8321 Belair Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> <u>120.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1949</u> to <u>Aug 12</u> , 1957, that I last saw the deceased alive on <u>Aug 9</u> , 1957, and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R Donald Jandorf</u> M.D. <u>6077 Harford Rd, Balt 14, Md</u>				DATE SIGNED <u>8-13-57</u>			
PHYSICIAN'S NAME (Type) <u>R Donald Jandorf</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Laurel Funeral Home</u>				ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR <u>AUG 15 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mr. L. L. Thompson</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 15 1957

RECEIVED

08329

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Oaks Nursing Home</u>				e. STREET ADDRESS <u>611 Whitelock St.</u>			
3. NAME OF DECEASED (Type or print) <u>Benjamin Raffel</u> First Middle Last				4. DATE OF DEATH <u>Aug. 7/57</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 6, 1892</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shop.</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Israel Raffel</u>				14. MOTHER'S MAIDEN NAME <u>Rosa Isaacson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs. Rosa Raffel - 611 Whitelock St.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]						INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General + cerebral arteriosclerosis</u>						<u>3 yrs.</u>	
X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						(b)	
						DUE TO	
						(c)	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> , 19, to <u>8/7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug. 1</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Milton B. Kirsh</u> M.D.				ADDRESS (Street, city or town, state) <u>2370 Rutaw Place</u> DATE SIGNED			
NAME (Type) <u>Milton B. Kirsh, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>8/9/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chapel Green</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Brown</u> ADDRESS <u>1124-26</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be filed with the funeral director. Pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 1957

BUREAU V. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08330

CERTIFICATE OF DEATH

Reg. Dist. No.

08329

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Kingsville c. LENGTH OF STAY IN 1b 7 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sunshine Avenue Kingsville				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Kingsville d. STREET ADDRESS Sunshine Avenue Kingsville e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Augusta		First Middle Last Rode		4. DATE OF DEATH Month Day Year 8 13 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1866		9. AGE (In years last birthday) 91 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Germany			
13. FATHER'S NAME William Emmart		14. MOTHER'S MAIDEN NAME Augusta Sachs					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Helen Ritchie Sunshine Ave. Kingsville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease M.D.O. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Cardiac Distention DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 years 15 minutes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that I attended the deceased from June 1946 to August 13, 1957 that I last saw the deceased alive on August 7, 1957 , and that death occurred at 6 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3025 Belair Road DATE SIGNED ACTUAL SIGNATURE William L. Feoring M.D. FURNERIAL NAME (Type) Lawson Funeral Home							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/16/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery			
22d. LOCATION (City, town, or county) Baltimore City Maryland		22e. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Lawson Funeral Home 2401 Belair Rd ADDRESS DATE AUG 15 1957 REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE							

BUREAU V. S.

AUG 15 1957

RECEIVED
FBI

MARYLAND STATE DEPARTMENT OF HEALTH

08330

08331

2411 N. Charles Street, Baltimore

Baltimore County
CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>md</u> COUNTY <u>1</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>4208 Waldman Ave</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>4208 Waldman Ave</u>	
3. NAME OF DECEASED (First) <u>Alonso</u> (Middle) <u>Leu</u> (Last) <u>Rose</u>		4. DATE OF DEATH (Month) <u>Aug</u> (Day) <u>25</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Reporter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>George Bros</u>	
13. FATHER'S NAME <u>Robert Rose</u>		14. MOTHER'S MAIDEN NAME <u>Annagene Ashburn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Mr Rose 4208 Waldman Ave</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
4 * Immediate cause (a) <u>Chronic Congestive Heart Disease</u>	<u>1 year</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Arterioscl. Heart Disease</u>	<u>+ 10 years</u>	
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 10, 1957 to Aug 25, 1957, that I last saw the deceased alive on Aug 23, 1957 and that death occurred at 11:40 a.m., from the causes and on the date stated above.

SIGNATURE John Hain(Degree or title) M.D.ADDRESS 520 D St Balt 19DATE SIGNED 8-26-57

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Aug 27 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Meadow Ridge</u>	LOCATION (City, town, or county) <u>Harvey Md</u>	(State)
24. REGISTRAR'S SIGNATURE <u>Lawson L. Farley</u>		24. FUNERAL DIRECTOR <u>Geo. S. Leach 1701-23 Patterson Park Ave</u>		

MARGIN RESERVED FOR INDEXING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

AUG 2 1953

BUREAU V. S.

C8332

CERTIFICATE OF DEATH

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Granite			c. LENGTH OF STAY in 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Granite, Maryland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Old Court Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Love Last Rupp				4. DATE OF DEATH Month August Day 16 Year 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 28, 1875		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James Henry Love				14. MOTHER'S MAIDEN NAME Ann Hall Worthington			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Augusta R. Monroe			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE C.V. DISEASE DUE TO (c) RENAL INSUFFICIENCY						INTERVAL BETWEEN ONSET AND DEATH 10 days - 10 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
					20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from JUNE 1 , 1950, to AUG-16 , 1957, that I last saw the deceased alive on AUG 16 , 1957, and that death occurred at 1 P. M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas E. Wheeler M.D.				ADDRESS (Street, city or town, state) 3601 Cypress Rd Baltimore - 816/57			
PHYSICIAN'S NAME (Type) THOMAS E. WHEELER				DATE SIGNED 8/16/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Worthington Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				ADDRESS Ellsworth Armacost - 4600 Liberty Hgts. Ave.		24a. REC'D BY REGISTRAR AUG 20 1957	
				24b. REGISTRAR'S SIGNATURE Dr. J. E. Martin			

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be examined within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 22 1957

RECEIVED

08333

CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 5 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3647 KEYSTONE AVENUE			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last LEONARD A. SARACIN				4. DATE OF DEATH Month Day Year AUGUST 28 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 27, 1910	
9. AGE (In years last birthday) 47 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Man				10b. KIND OF BUSINESS OR INDUSTRY Laundry			
11. BIRTHPLACE (State or foreign country) BRIDGEPORT, CONNECTICUT				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME FRANK P. SARACIN				14. MOTHER'S MAIDEN NAME MARGARET SALVANGNE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO 048-01-6657		17. INFORMANT CLIN. REC., VET. ADM. HOSPITAL, FT. HOWARD, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). UNLISTED TUMOR OF LUNG, MALIGNANT 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from August 23, 1957 to August 28, 1957 and that death occurred at 12:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA HOSPITAL, FORT HOWARD, MARYLAND 8/29/57							
ACTUAL SIGNATURE Abraham A. Polachek, M.D.							
PHYSICIAN'S NAME (Type) ABRAHAM POLACHEK, M.D. Asst. Chief, Medical Service							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-29-57		22c. NAME OF CEMETERY OR CREMATORY Private Cemetery BRIDGEPORT, CONNECTICUT		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.				24a. REC'D BY REGISTRAR 9/4/57		24b. REGISTRAR'S SIGNATURE Lawson L. Parker	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SHIPPED TO:

RICHARD SPABACCINO, 499 WASHINGTON AVE., BRIDGEPORT, CONN.

BUREAU V. S.

SEP 5 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 38

08334

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN Rural: TowsonLENGTH OF STAY
(in this place)HOSPITAL OR INSTITUTION OR STREET ADDRESS
Eudowood Sanatorium
Towson 4, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN Baltimore 15STREET ADDRESS
(If rural give location)
2540 Gunther Ave

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

PHILIP

SCHEININ

4. DATE OF DEATH:

(Month)

(Day)

(Year)

8

24

1957

5. SEX:

M

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

M

8. DATE OF BIRTH:

10/11/1892

9. AGE last birthday:

64 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

Foreman

10b. KIND OF BUSINESS OR INDUSTRY:

Garment Factory

11. BIRTHPLACE (State or foreign country):

Russia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Jacob Scheinin

14. MOTHER'S MAIDEN NAME:

Bertha Berlin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Personal History

Hospital Records, Eudowood Sanatorium

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

Carcinoma Lung

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

10 mos

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1957, to Aug. 24, 1957, that I last saw the deceased

alive on Aug. 16, 1957, and that death occurred at 12:30 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Walter B. Kues M.D.

Eudowood Sanatorium - Towson 4, Maryland

8/24/57

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (city, town, or county)

(State)

Burial

8-25-57

Rosedale

Baltimore, Md

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

F. FUNERAL DIRECTOR

ADDRESS

AUG 25 1957

Huntington, N.Y.

Jacob Lewin 2100 Eutaw Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 12 1957

BUREAU V. S.

08335

CERTIFICATE OF DEATH

08334

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institutional: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF JOHN First Middle Last				4. DATE OF DEATH August 21 19 57 Month Day Year			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1914	
9. AGE (In years last birthday) 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Schmidt, Sr.				14. MOTHER'S MAIDEN NAME Lillian Siebert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Yes WW II				16. SOCIAL SECURITY NO 214-26-8168			
17. INFORMANT Clin. Rec., Vet. Administration Hospital, Ft.				Address Howard, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]							
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) INTRACEREBRAL HEMORRHAGE AND SUBARACHNOID HEMORRHAGE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 13 19 57 to August 21 19 57 , and that death occurred at 3:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Chien Wei Lan				M.D. VAH Ft. Howard, Md 8/21/57			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.				VAH, FT HOWARD, MD 8/21/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF AUG 23-1957		22c. NAME OF CEMETERY OR CREMATORY Baltimore National CEM		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Dippel Bros. John J. Dippel				24a. REC'D BY REGISTRAR AUG 21		24b. REGISTRAR'S SIGNATURE Dawson L. Farber	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

AUG 23 1967

RECEIVED

08335

08336

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Res dence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NOTCH CLIFF NEAR TOWSON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GLENARM ROAD</u>		d. STREET ADDRESS <u>GLENARM ROAD</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SISTER MARY SOPHIE SCHULTE</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 8 1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 8, 1862</u>
9. AGE (In years last birthday) <u>94</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>GERMANY</u>	
13. FATHER'S NAME <u>AUGUST</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH GRANITATH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>SISTER M. PETER FOURIER</u>		Address <u>NOTCH CLIFF</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PEMPHIGUS</u> <u>4.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 mos.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>APRIL</u> , 1953, to <u>AUGUST</u> , 1957, that I last saw the deceased alive on <u>JULY 20</u> , 1957, and that death occurred at <u>4 A.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>7501 YORK ROAD TOWSON 4, Md 8/8/57</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES F. O'DONNELL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-12-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM</u>	22d. LOCATION (City, town, or county) (State) <u>NOTCH CLIFF NEAR TOWSON, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Guler</u>		24a. REC'D BY REGISTRAR <u>901 S. CONKLING ST BALTO., 24, MD</u>	24b. REGISTRAR'S SIGNATURE <u>Mabel Grepp</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 12 1957
NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3, should be filed with the funeral director. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08337

CERTIFICATE OF DEATH

08336

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randellstown, Maryland</u>		c. LENGTH OF STAY IN 1b <u>about 5 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wards Chapel Rd.</u>		d. STREET ADDRESS <u>1310 Asquith st.</u>	
3. NAME OF DECEASED (Type or print) <u>William J. Schuman</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-22-1893</u>
9. AGE (In years last birthday) <u>63 yrs.</u>		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>9</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Freight Assessor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.R. Express</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>yes U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Lena Schuman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>714-0346</u>	
17. INFORMANT <u>Andrew J. Schuman</u>		Address <u>3333 Eppa Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u> <u>1561</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-27</u> , 19 <u>57</u> , to <u>8-1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-31</u> , 19 <u>57</u> , and that death occurred at <u>3A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Leon Ashman</u>		M.D. <u>5907 Hargan Oak Ave</u>	
PHYSICIAN'S NAME (Type) <u>LEON ASHMAN</u>		DATE SIGNED <u>Balto, 7, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>8-5-57</u>	<u>Bel Air Memorial Gardens - Bel Air Md.</u>	<u>Balto Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Ruth Inc</u>		ADDRESS <u>1735 Hanford Ave</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 5</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Amos M. ...</u>	

BUREAU V. S.

AUG 5

RECEIVED

MARYLAND

08338

CERTIFICATE OF DEATH

08338

Reg. Dist. No.

32

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Pikesville</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
		d. STREET ADDRESS <u>207 Sudbrook Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Fannie</u> First <u>Frances</u> Middle <u>Shipley</u> Last		4. DATE OF DEATH <u>August 25</u> Month <u>1957</u> Day <u>1957</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 11, 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retail store</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Garrish</u>		14. MOTHER'S MAIDEN NAME <u>Kathrine Lorey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO <u>219-10-2942</u>	
17. INFORMANT <u>Mr. E. Glen Shipley</u>		Address <u>Pikesville 207 Sudbrook Lane</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Breast</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u> </u> Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 24, 1956</u> to <u>Aug 25, 1957</u> , that I last saw the deceased alive on <u>Aug 24, 1957</u> , and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Miller, M.D.</u>		ADDRESS (Street, city or town, state) <u>Pikesville-2, Md</u>	
PHYSICIAN'S NAME (Type) <u>James A. Miller, M.D.</u>		DATE SIGNED <u>8/26/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 28, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Stone Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul H. Newell</u>		ADDRESS <u>Pikesville, Md</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Brooklyn Newell</u>	

BUREAU V. S.

AUG 27 1917

RECEIVED

08339

CERTIFICATE OF DEATH

08338 38

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home 301 West Chesapeake Avenue		d. STREET ADDRESS 6436 Blenheim Road • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Strouss Last Shore		4. DATE OF DEATH Month August Day 6 Year 1957	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1902 9. AGE (In years last birthday) yrs. 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pittsburgh, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William A. Strouss		14. MOTHER'S MAIDEN NAME Caroline J. Gilmore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Wm. M. Shore		Address 6436 Blenheim Road, Baltimore 12	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Liver 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Descending Colon DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 8 Months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 10, 1957 to Aug 6, 1957 , that I last saw the deceased alive on Aug 6, 1957 , and that death occurred at 12:43 AM from the causes and on the date stated above.			
ACTUAL SIGNATURE Laurence C. Post		ADDRESS (Street, city or town, state) 6805 York Rd DATE SIGNED	
PHYSICIAN'S NAME (Type) LAURENCE C. POST M.D.		Baltimore 12 Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-8-57	22c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery	22d. LOCATION (City, town, or county) (State) Norristown, Pa.
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR DATE 8/9/57	24b. REGISTRAR'S SIGNATURE Malcolm G. [Signature]

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 7
BUREAU V. S.

08340

CERTIFICATE OF DEATH

083394

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md. c. LENGTH OF STAY IN 1b 42 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall d. STREET ADDRESS RFD 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DANIEL Middle S. Last SIX		4. DATE OF DEATH Month August Day 2 Year 19 57					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 20, 1890		9. AGE (In years last birthday) 66 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) White Hall, Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jerry Six		14. MOTHER'S MAIDEN NAME Jane Wilson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I		16. SOCIAL SECURITY NO 218-05-0249		17. INFORMANT Clin Records, Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA OF PENIS (SURGICALLY REMOVED) WITH SKIN AND REGIONAL LYMPHOID METASTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XX DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA RIGHT LOWER LOBE 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year 19 57 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State) 20h. (City or town) (County) (State)							
21. I certify that I attended the deceased from June 21, 19 57 to August 2, 19 57 and that death occurred at 2:30P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Veterans Administration Hospital DATE SIGNED 8/3/57 ACTUAL SIGNATURE Chien Wei Ian M D NAME (Type) CHIENT WEI IAN, M. D. Fort Howard, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 5/1957		22c. NAME OF CEMETERY OR CREMATORY West Liberty Cemetery			
22d. LOCATION (City, town, or county) Whitehall, Maryland		22e. (State) Maryland		22f. (City, town, or county) Whitehall, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Dr. Jacob Hartenstein, New Freedom, Pa.		ADDRESS New Freedom, Pa.		24. REG'D BY REGISTRAR Aug 6 1957			
24a. REGISTRAR'S SIGNATURE Dawson L. Turkey		24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

RECEIVED

1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08340

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Butler</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Butler</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Falls Rd</u>		d. STREET ADDRESS <u>Falls Rd</u>	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Benjamin</u> First <u>Kirklyn</u> Middle <u>Smith</u> Last		4. DATE OF DEATH <u>August</u> Month <u>21</u> Day <u>1957</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1891</u>
		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore County</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13. FATHER'S NAME <u>Joseph Smith</u>	14. MOTHER'S MAIDEN NAME <u>Louisa Williams</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>215323304</u>	17. INFORMANT <u>Ethel Smith</u> Address <u>Route 2 Brandywine Md</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>5 yrs</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 7, 1957, to Aug. 21, 1957, that I last saw the deceased alive on 21 Aug, 1957, and that death occurred at 11:04 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE <u>Walter T. Kees</u>	M.D. <u>Cockeyville</u>	DATE SIGNED <u>21 Aug 1957</u>
PHYSICIAN'S NAME (Type) <u>Walter T. KEES</u>		<u>Cockeyville Md</u>

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 24/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gough Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Cockeyville, Md.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Eline & Sons, Reisterstown, Md.</u>	24a. REC'D BY REGISTRAR <u>8-21-57</u>	24b. REGISTRAR'S SIGNATURE <u>Mary B Sline</u>
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RECEIVED

JUN 23 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1808341
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prager	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1920 Crafton Ave.		e. STREET ADDRESS 1920 Crafton Ave.	
3. NAME OF DECEASED (Type or print) Willard R. Snyder		4. DATE OF DEATH Aug. 29 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1905
9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sample Carrier		10b. KIND OF BUSINESS OR INDUSTRY Standard Oil Co.	
11. BIRTHPLACE (State or foreign country) Dixon City-Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Snyder		14. MOTHER'S MAIDEN NAME Ellen Meyers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 149-09-5249	
17. INFORMANT Emma Snyder		Address 1920 Crafton Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion (b) A-S-C-V Disease (c) Diabetes Mellitus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B. DAVIS M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal Burial		22b. DATE THEREOF 9-2-57	
22c. NAME OF CEMETERY OR CREMATORY Christ Luth. Cem.		22d. LOCATION (City, town, or county) (State) German Hill Rd.	
23. FUNERAL DIRECTOR'S SIGNATURE John C. Miller Inc.		ADDRESS -2431 E. Oliver St.	
24a. REC'D BY REGISTRAR SEP 3		24b. REGISTRAR'S SIGNATURE John Kelly	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 3 1957

BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08342

CERTIFICATE OF DEATH

08342

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Moreland Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CARRIE Middle MAY Last STOVER				4. DATE OF DEATH Month August Day 18 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1874	
9. AGE (In years last birthday) 83 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY Penna.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Christopher H. Stover			
14. MOTHER'S MAIDEN NAME Cecelia B. Hunter				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.			
16. SOCIAL SECURITY NO. Jennie Simmons 330 Townsend Ave-21				17. INFORMANT Jennie Simmons 330 Townsend Ave-21			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic H.P. Disease DUE TO (c) Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 hrs 5 mos 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Dec 5 , 19 56 , to Aug 18 , 19 57 , that I last saw the deceased alive on Aug 18 , 19 57 , and that death occurred at 7:00 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James T. Mearns				ADDRESS (Street, city or town, state) 520 N. St. Ba 110. 15 md			
PHYSICIAN'S NAME (Type) James T. Mearns				DATE SIGNED 8/19/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Aug. 19, 1957		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill		22d. LOCATION (City, town, or county) (State) Columbia, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.				24a. REC'D BY REGISTRAR 8/20/57		24b. REGISTRAR'S SIGNATURE Jewson L. Farley	

RECEIVED

JUN 7 1957

BUREAU V. S.

CERTIFICATE OF DEATH

083433

Reg. Dist. No. 33

08343

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beekleysville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beekleysville</u>	
c. LENGTH OF STAY in 1b <u>1 year</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALVIN</u> First <u>R</u> Middle <u>-</u> Last <u>STREUBIG</u>		4. DATE OF DEATH <u>Aug 28</u> Month <u>Aug</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 14 - 1879</u>
9. AGE (In years, last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>now worker</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ephraim B Streubig</u>		14. MOTHER'S MAIDEN NAME <u>Irene Fowble</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-05-7129</u>	
17. INFORMANT Address <u>Mrs Alvin Streubig Hampstead Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cornary - Insufficiency</u> DUE TO (c) <u>Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>10420</u> <u>15420</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Aug 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 27</u> , 19 <u>57</u> , and that death occurred at <u>8</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u>		DATE SIGNED <u>Aug 31 1957</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield</u>		<u>Hampstead, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Aug 31/57</u>	<u>Grave Run</u>	<u>Balto Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin C. Lipton</u>		24a. REC'D BY REGISTRAR <u>8-31-57</u>	
ADDRESS <u>Hampstead Md</u>		24b. REGISTRAR'S SIGNATURE <u>Mary B. Fine</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PUREAU V

SEP 4 1957

RECEIVED

3-31-57

08344

Item 7 filed 12-27-57 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore Md.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Balto City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>				c. LENGTH OF STAY IN 1b <u>3 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor Aged Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>D.</u> Last <u>Swan</u>				4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 8-1888</u>	
9. AGE <u>69</u> years (last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Baltimore</u>				13. FATHER'S NAME <u>Charles Thomas Swan</u>			
14. MOTHER'S MAIDEN NAME <u>Laura Bollman</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or date of service) <u>yes</u> <u>World War</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Urinary tract infection & septicemia</u> <u>610X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prostatic hypertrophy</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized atherosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10-28</u> , 19 <u>54</u> , to <u>present</u> , 19 <u>57</u> that I last saw the deceased alive on <u>7/31</u> , 19 <u>57</u> , and that death occurred at <u>4 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1101 N. Calvert St - 2</u> DATE SIGNED <u>Ernest C Brown</u> ACTUAL SIGNATURE <u>Ernest C Brown</u> M.D. <u>1101 N. Calvert St - 2</u> PHYSICIAN'S NAME (Type) <u>ERNEST C BROWN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto</u> <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Homes</u> ADDRESS <u>Balto Md</u>				24a. REC'D BY REGISTRAR <u>AUG 5 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Quelan</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 5 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08345

08239

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				c. LENGTH OF STAY IN 1b Baltimore 27 (Arbutus)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5528 Council St.				d. STREET ADDRESS 5528 Council St.			
3. NAME OF DECEASED (Type or print) ROSS PRICE TARR				4. DATE OF DEATH Month August Day 1 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1897	9. AGE (In years last birthday) 60 yrs	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Months Days Hours	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automotive		11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Richard Simpser Tarr				14. MOTHER'S MAIDEN NAME Mary Victoria Price			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-031-8960		17. INFORMANT Address Helen A. Tarr, Baltimore 27, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma - upper lobe - rt. lung - with metastases to liver - DUE TO (b) Metastases to liver - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) None PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET AND DEATH 8 hrs +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. s. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) None	
21. I certify that I attended the deceased from 1940 to Aug 1 , 1957, that I last saw the deceased alive on July 31st , 1957, and that death occurred at 7:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Frederic J. Butler M.D. 1014 Frances Ave - Baltimore - Md PHYSICIAN'S NAME (Type) Frederic J. Butler							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-5-57		22c. NAME OF CEMETERY OR CREMATORY Springfield		22d. LOCATION (City, town, or county) (State) Sykesville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F. C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR AUG 6 1957		24b. REGISTRAR'S SIGNATURE Dr. M. Kieffer	

REAU V. S.

1902

1902

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08345

CERTIFICATE OF DEATH

08346

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 TOWSON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1022 HART RD.		d. STREET ADDRESS 1 1022 HART RD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last AMBROSE MEADE TAYLOR		4. DATE OF DEATH Month Day Year AUG 30 19 57	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-3-65
9. AGE (In years last birthday) 9.2 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS TAYLOR		14. MOTHER'S MAIDEN NAME JULIEN ORNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. BRADFORD PETERSON		Address 1022 HART RD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LIP 140X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 18 MOS.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April , 19 57 , to Aug 30 , 19 57 , that I last saw the deceased alive on Aug 28 , 19 57 , and that death occurred at 9:15 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE William A Pillsbury M.D.		ADDRESS (Street, city or town, state) TIMONIUM MD DATE SIGNED 8/30/57	
PHYSICIAN'S NAME (Type) WILLIAM A PILLSBURY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 1, 1957	22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	22d. LOCATION (City, town, or county) (State) Frederick Co. Adams Co. Pa.
23. FUNERAL DIRECTOR'S SIGNATURE J. Martin Bender ADDRESS Hethsburg, Pa.		24. REC'D BY REGISTRAR SEP 3 1957 24b. REGISTRAR'S SIGNATURE Metel Gray	

BUREAU V. S.

SEP 3 1957

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08346

08347

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville	
c. LENGTH OF STAY IN 1b 1 mo. 17 days		d. STREET ADDRESS u x x a l	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital		e. I. RES. OFN. E. C. N. A. F. R. M. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John H. Thomas	4. DATE OF DEATH 8 21 19 57	5. AGE (In years last birthday) 70 yrs.	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH ?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY ?	
13. FATHER'S NAME Thomas Thomas		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Records of Spring Grove State Hospital		Address Records of Spring Grove State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Geo. S. M. Kieffer		DATE SIGNED 8-22-57	
EXAMINER'S NAME (Type) Geo. S. M. Kieffer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) 26 Aug. 57	22b. DATE THEREOF 26 Aug. 57	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery	22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Long & Turner		24a. REC'D BY REGISTRAR A G	24b. REGISTRAR'S SIGNATURE educh

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 1957
BUREAU V. A.

08234

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY 1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) 118 Williams Avenue		d. STREET ADDRESS 118 Williams Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last W. ALBERT THUMA, SR.		4. DATE OF DEATH Month Day Year August 29, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1895
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) proprietor		10b. KIND OF BUSINESS OR INDUSTRY tea room	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willis A. Thuma		14. MOTHER'S MAIDEN NAME Louise Bechtold	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-20-6068	
17. INFORMANT Mrs. M. Elizabeth Thuma		Address 118 Williams Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19 48 to 29 Aug. , 19 57 , that I last saw the deceased alive on 29 August 1957 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE B. W. Soklod, M.D.		ADDRESS (Street, city or town, state) 2900 Dundan Rd Dundalk - 22 - Md	
PHYSICIAN'S NAME (Type) B. W. Soklod, M.D.		DATE SIGNED 8-30-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 2, 1957	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. SANDER & SONS, INC. Baltimore, Md.		24a. REC'D BY REGISTRAR SEP 3 1957	
		24b. REGISTRAR'S SIGNATURE Mr. Kelly	

RECEIVED

SEP 3 1937

BUREAU V. 31

08347

CERTIFICATE OF DEATH

08349 45

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Long Beach		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Long Beach	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Chesapeake Avenue	
3. NAME OF DECEASED (Type or print) First HARRY Middle H Last TROST		4. DATE OF DEATH Month Aug. Day 18 Year 1957	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1886
9. AGE (In years last birthday) 71 yrs		IF UNDER 1 YEAR: Months 7 Days 18 Hours 18 Min 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY Own Tavern	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry Trost		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Laura A. Henze Trost, wife, above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO (c) Generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 8 yrs 3 yrs 10 + yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asthmatic bronchitis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1956 to 8/18, 1957 , that I last saw the deceased alive on 8/16, 1957 , and that death occurred at 9 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. PLATT, M.D.		ADDRESS (Street, city or town, state) 434 Eastern Ave. Essex, Md.	
DATE SIGNED 8/19/57		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 21, 1957	
22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek		ADDRESS 3331 Brehms Lane	
24a. REC'D BY REGISTRAR DATE 21 1957		24b. REGISTRAR'S SIGNATURE Edith Henze	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM V. S.

1871

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08348

CERTIFICATE OF DEATH

08350

Reg. Dist. No.

22

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CITY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) Mt. Wilson State Hospital		d. STREET ADDRESS 1523 MARSHALL STREET	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle TRUST Last TRUST		4. DATE OF DEATH Month AUGUST 22 Day 19 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4. 30. 01
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UPHOLSTERER		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HERMAN TRUST		14. MOTHER'S MAIDEN NAME MAY COULTER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO Hospital Records, Mt. Wilson State Hospital	
17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) COR PULMONALE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY TUBERCULOSIS DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days 11 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour 19 Month 13 Day 21 Year 1957 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-13, 1956, to 8-21, 1957 , that I last saw the deceased alive on 8-21, 1957 , and that death occurred at 12:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Mt. Wilson, Maryland DATE SIGNED			
ACTUAL SIGNATURE William Newcomer M.D. Mt. Wilson, Maryland			
PHYSICIAN'S NAME (Type) William Newcomer, M.D., Superintendent			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8-26-57	
22c. NAME OF CEMETERY OR CREMATORY Mt. Wilson		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Newcomer		24. REC'D BY REGISTRAR Aug 23 1957	
ADDRESS Hospital Records, Mt. Wilson State Hospital		24b. REGISTRAR'S SIGNATURE Donna J. Newcomer	

U.S. AIR FORCE

AUG 23 1957

RECEIVED

08349

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>White Marsh R.D.,</u>		<u>Lifetime</u>		TOWN <u>White Marsh R.D.,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<u>1 Lorley</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Jules</u> (Middle) <u>W</u> (Last) <u>Venzke</u>				(Month) <u>Aug</u> (Day) <u>24</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS
<u>male</u>	<u>white</u>	<u>single</u>	<u>Apr. 15, 1997</u>	<u>60</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>machine operator</u>		<u>State Road</u>		<u>Balto., Co., Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Louis Venzke</u>				<u>Louise Cage</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>216-05-0094</u>		<u>Herman Venzke, Bradshaw, Maryland.</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>				<u>10 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Hemorrhage July 1955</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M. <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Aug 24</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 24</u> , 19 <u>57</u> , and that death occurred at <u>11:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Otto H. H. H.</u>				ADDRESS (Street, city, town, state) <u>Edgewood Md</u>			
DATE SIGNED <u>Aug 24</u>				DATE SIGNED <u>Aug 24</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>Aug 27, 1957</u>		<u>Trinity Lutheran</u>		<u>Joppa, Harford, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>AUG 29 1957</u>		<u>Dr. Walter H. H.</u>		<u>Howard K. H.</u>		<u>Abingdon, Md</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

BUREAU V. S.

AUG 29 1907

RECEIVED

08350

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines, 16 Fusting Ave.		d. STREET ADDRESS 1910 Wilhelm Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Ruth Naomi Wagner		4. DATE OF DEATH Month Day Year Aug. 7, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1900
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME late Wm. Thompson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT (SON) Charles Wagner, 1739 White Oak Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Hypertensive Cardio-Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 7 ds. 5 yrs. (?)
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7-12 , 19 57 , to 8-7 , 19 57 , that I last saw the deceased alive on 8-6 , 19 57 , and that death occurred at 5 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wilmer K. Gallagher		ADDRESS (Street, city or town, state) DATE SIGNED 6209 Frederick Rd. 8-9-57	
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher		Catonsville 2E, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 10/57	22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Nitzke, Funeral Directors, 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR Aug 14 '57	
24b. REGISTRAR'S SIGNATURE Overhach			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

AUG 15 1957

BUREAU V. S.

08351

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Notch Cliff near Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XJ Rural Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road		d. STREET ADDRESS Glenarm Road	
3. NAME OF DECEASED (Type or print) Sr. Mary Villanova Wankmueller		4. DATE OF DEATH Month August Day 8 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 21, 1872
9. AGE (In years last birthday) 84 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Newark, N.J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph		14. MOTHER'S MAIDEN NAME Katherine Koelock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Sister M. Peter Fourier		Address Notch Cliff Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastasis of the lung 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca. of breast DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1952 , to July 1957 , that I last saw the deceased alive on July 30 1957 , and that death occurred at 9:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles F. O'Donnell		M.D. 7501 York Road Towson, 4. Md. 8. 8. 57	
PHYSICIAN'S NAME (Type) Charles F. O'Donnell			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	8-10-57	VILLA MARIA CEM	NOTCH CLIFF NR TOWSON, MD
23. FUNERAL DIRECTOR'S SIGNATURE Charles F. O'Donnell		24a. REC'D BY REGISTRAR 8/9/57	
ADDRESS 901 S. CONKLING ST. BALTIMORE, MD		24b. REGISTRAR'S SIGNATURE Mark L. Gray	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
AUG 12 1907
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08352

08355

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar for a burial, cremation or removal.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORT HOWARD, MD.</u>				c. LENGTH OF STAY IN TB <u>DOA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>VETERANS ADMINISTRATION HOSPITAL</u>				e. STREET ADDRESS <u>1602 Johnson Street</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>M.</u> Last <u>WEIR</u>				4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/21/86</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		(FUNDER) YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Personnel Mgr.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Department Store</u>		11. BIRTHPLACE (State or foreign country) <u>Cincinnati, Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John M. Weir</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Phillips</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I</u>		17. INFORMANT <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, BILATERAL WITH ABSCESS FORMATION</u> <u>EMPHYSEMA, LEFT LOWER PLEURAL CAVITY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>UNKNOWN</u> (c) <u>UNKNOWN</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL EDEMA AND CONGESTION - Duration unknown</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M B Davis</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. Md.</u>				24a. REC'D BY REGISTRAR <u>9/4/57</u>		24b. REGISTRAR'S SIGNATURE <u>L. Harbey</u>	

RECEIVED

SEP 5 1957

BUREAU U. S.

08353

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1 PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2 USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. VA MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 4 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
f. STREET ADDRESS 3307 KENYON AVENUE				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARRY		First		Middle		Last	
4. DATE OF DEATH AUGUST		Month		Day		Year	
27		19		57			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 22, 1892	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard - Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government Post Office		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Weitzel				14. MOTHER'S MAIDEN NAME Louise Keidel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Address Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIRRHOSIS OF LIVER							UNKNOWN
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MASSIVE ASCITES							UNKNOWN
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Hour a. m. p. m.	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from August 23, 1957 , to August 27, 1957				and that death occurred at 1:45 A.M. , from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Chien Wei Lan</i>				ADDRESS (Street, city or town, state) VA HOSPITAL, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D.				DATE SIGNED 8/27/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/30/57		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Schimunek Funeral Home, 3331 Brehms Lane, Balto. 13				24a. REC'D BY REGISTRAR DATE 8/29/57		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Farberg</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JUN 29 1967
BUREAU V. S.

08354

CERTIFICATE OF DEATH

08357

Reg. Dist. No.

43

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) b. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 428 Buck's School House Rd.		d. STREET ADDRESS Box 428 Buck's School House Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jesse Middle F. Last White		4. DATE OF DEATH Month August Day 25 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1886
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Engineer-Retired		10b. KIND OF BUSINESS OR INDUSTRY Merchant Marine	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Thomas White		14. MOTHER'S MAIDEN NAME Mary E. Ford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Annie L. White		Address Box 428 Buck's School House Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis-Generalized Adu DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days under	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pulmonary Disease - many yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY , 19 43 to 25 Aug , 19 57 , that I last saw the deceased alive on 4:30 p.m. 25 Aug 57 and that death occurred at 5:39 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7527 Belair Rd. Baltob DATE SIGNED 8-27-57 ACTUAL SIGNATURE John C. Hyle M.D. PHYSICIAN'S NAME (Type) JOHN C. Hyle			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 29, 1957	
22c. NAME OF CEMETERY OR CREMATORY St. Peter's Lutheran		22d. LOCATION (City, town, or county) (State) Belair Rd. Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		24. REC'D BY REGISTRAR Aug 29 1957	
ADDRESS 7401 Belair Rd.		25. REGISTRAR'S SIGNATURE Mrs. R. L. K. K. K.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

AUG 29 1957

RECEIVED

08355

CERTIFICATE OF DEATH

08358

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Fullerton</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>39 Sipple Avenue</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Rural Fullerton</u> d. STREET ADDRESS <u>39 Sipple Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Lee Willinger</u>		4. DATE OF DEATH Month Day Year <u>8 13 1957</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/14/1881</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>75</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Milton Greenwood</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Ruth Ryan</u> Address <u>39 Sipple Avenue</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)														20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that I attended the deceased from <u>1954</u> to <u>Aug 13, 1957</u> that I last saw the deceased alive on <u>Aug 1, 1957</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6077 Harford Rd. Balto., Md 8-14-57</u> ACTUAL SIGNATURE <u>R Donald Wendorf</u> M.D. PHYSICIAN'S NAME (Type) <u>R Donald Wendorf</u>																					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>8-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loevehn Funeral Home 7401 Belair Rd.</u>						24a. REC'D BY REGISTRAR <u>AUG 15 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. L. R. Rasmussen</u>													

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MIG 15 1957

BUREAU W. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08359

08356

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) 810 C St.		e. STREET ADDRESS 810 C St.	
3. NAME OF DECEASED (Type or print) First Florence Middle I. Last Wittich		4. DATE OF DEATH Month Aug. Day 4 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1886
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 8 Days 15 Hours 45 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME -----Hand		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Charles Wittich, 810 C St. Sparrows Pt. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremic acidosis DUE TO (c) Arteriosclerotic Cardiovascular Renal Disease		INTERVAL BETWEEN ONSET AND DEATH 8 hours 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 25, 1957 to Aug. 4, 1957 that I last saw the deceased alive on Aug. 4, 1957 and that death occurred at 1:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 914 D Street Balto. 19, Md. DATE SIGNED 8/4/57		ACTUAL SIGNATURE David Owens M.D. 914 D Street PHYSICIAN'S NAME (Type) David Owens Balto. 19, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 7/57	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore 29, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors, 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR Aug 7 1957	
24b. REGISTRAR'S SIGNATURE Dawson			

CERTIFICATE OF DEATH

BUREAU V. 3

AUG 7 1957

RECEIVED

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN TB 30 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrills <i>02x12</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS RFD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First EDWIN		Middle J.		Last YOUNG	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 7, 1923	
				9. AGE (In years last birthday) yrs. 33		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edwin B. Young				14. MOTHER'S MAIDEN NAME Grace Purdham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) Yes		(If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 212-20-4479		17. INFORMANT Address Clin.Rec.Vet.Adm.Hospital,Ft.Howard,Maryland	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HODGKIN'S DISEASE WITH METASTASES TO RIGHT LOWER LOBE, LIVER AND SPLEEN <i>201X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 6 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from July 9, 1957 , to August 8, 1957 . XXXXXX and that death occurred at 12:08A , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA HOSPITAL, FORT HOWARD, MARYLAND 8/8/57 ACTUAL SIGNATURE <i>Chien Wei Lan</i> M.D. PHYSICIAN'S NAME (Type) CHIEN WEI LAN, M.D. FORT HOWARD, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 12, 57		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Cem.		22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> ADDRESS Popping Funeral Home, 272 West St. Annapolis, Md.				24. REC'D BY REGISTRAR DATE AUG 12 1957 REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
Race		Marital Status		Occupation		Place of Birth	
Usual Residence		Cause of Death		Manner of Death		Date of Death	
Physician's Signature		Medical Examiner's Signature		Coroner's Signature		Registrar's Signature	
Hospital or Place of Death		City		County		State	

RECEIVED
 AUG 12 1957
 BUREAU K. S.